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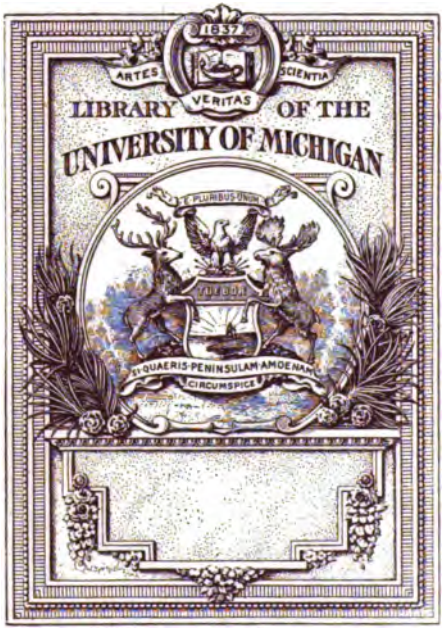
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CANADA

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A Monthly Record of

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EDITED BY

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INDEX TO VOL. XII.

PAGE

Abortion, Treatment of 20
Abscess, Psoas, New treatment of... 474
Abscess of Liver; dysenteric..... 330
Acid carbolic as local anæsthetic.... 364
Aconite in Diphtheria..... 390
Actinomycosis, Case of..... 599
Albuminuria, Puerperal..... 577
Alloway, T. J., M.D.:
On Axis Traction Hook..... 303
On Flesh Mole Placenta..... 429
On Puerperal Fever..... 456
On Tracheotomy..... 104
Alopecia Prematura..... 288
Amyloid Liver..... 103
Anæmia Idiopathic..... 696
Anæsthetics..... 96
Aneurism of Abdominal Aorta and
" Superior Mesenteric Artery 294
" Aortic; rupture into bronchus 426
" Vertebral, Traumatic.... 618
" Sub-clavian, Ligature of Innominate for..... 99
" of Anterior Cerebral Artery 34
" Case of Gluteal..... 749
Antiseptic Puerperal Dressing 497
" Obstetrical Methods..... 558
" Absorbent Sponge..... 704
Antiseptics, Later in Private Practice..... 693
Anti-vivisection Agitation..... 758
Aphasia..... 692
Arch, Palmar, Wound of..... 36
Armstrong, G. E., M.D., Case of Tait's Operation..... 359
Artery, Femoral, Wound of..... 307
" Axillary, Ligature of 238
" Aneurism of Anterior Cerebral..... 34
Aryan Views of Doctors 623

Bedsores, Prevention of..... 470
Bell, James, M.D.:
On Resection of Intestines. 118
On Syphilis of Os and Cervix Uteri 175
On Fracture of Femur..... ... 687
Berlin, Letter from..... 668
" Letter from..... 582
Billroth, Antiseptic Ovariotomy..... 4
Birth, Triple, Case of..... 483
Bladder, Rupture of..... 619
Blood, Desiccated, Uses of..... 541
Boracic Acid in Ear Diseases 697
Botsford, Dr, on Inflation of Lungs.. 111
Brain of a Monkey..... 741
Breech-presentations, Forceps in.... 751
Bright's Disease, New Views on..... 499
" " Some Features in.. 121
Bronchoceles, Treatment of Large.. 469
Buboes, Treated by Pressure 665

PAGE

Buller, F., M.D., on Common Errors in Ophthalmic Practice..... 147

Cachexia Strumepriva..... 672
Calculus, Renal, Remarkable Case of 524
Campbell, F. W.:
Nitroglycerine in Epilepsy 43
On Femoral Hernia..... 117
Cases of Obstetrics..... 165
Case of Femoral Hernia..... 321
Campbell, J., M.D., on Sciatica 719
Canada Medical Association, Annual Meeting 107
Cancer, Uterine, Case of..... 347
Carbonic Acid for Insufflation..... 501
Caries, Syphilitic, of Skull..... 351
Cæsarian Operation, Present Aspect of 14
Castration, in Women, Indications for 25
Catheter Fever..... 465
Cerebellum, Hæmorrhage into the... 741
Chancre, Phagedenic, Treatment of . 476
Chilblains, Treatment of 361
Children, Bandy-legged Irish..... 748
Chisholm, M., M.D., Aconite in Diphtheria 390
Cholecystotomy, Tait on..... 666
Cider in Calculous Persons..... 500
Circumcision, Modern..... 811
Clavicle, Dislocation of Acromial end of 629
Cleanliness after Surgical Operations 223
Color-blindness..... 122
Copaiba, Action of on Urine..... 538
Colic Uterine, Iodoform in..... 589
Colon, Perforation of..... 354
Comedones, Pomades for 372
Conduct of Medical Men towards each other..... 112
Condylomata, Treatment by Carbolic Acid..... 98
Congress of German Surgeons..... 668
Copper, Sulphate of, in Obstetrics... 586
Currie, John Z., Report of Cases.... 85
Cystitis, Lecture on..... 642
Cysts, Ovarian, in an Infant..... 302
Cysts, Dermoid..... 604

Diet, Milk, in Childhood 605
" as a Therapeutic Agent 109
Digitalin, not Digitalisin..... 29
Diphtheria, Acomite in..... 390
Disinfectants, Note on..... 56
Dislocation of Elbow, Reduction of.. 95
Dorland, James, M.D., on Successive Dropsies of Amnion..... 201
Dressing, A New, for Wounds 309
Dropsies, Successive, of Amnion.... 201
Duncan, G. M., Excision of Tongue.. 6
Dupuis, Dr., on Medical Ethics..... 112
Dysentery, Cases of..... 330
Dysentery, Diphtheritic..... 612
Dysmenorrhœa..... 224

179859

PAGE

Ear, Maggots in the 271
Eclampsia, Puerperal, Pilocarpine in 588
" Puerperal 349
Edinburgh, Tercentenary at..... 625

EDITORIAL:

Territorial Representation..... 56
Roma locuta est. Causa finita est..... 57
M. Souvelle Caught in the Act .. 59
New Brunswick Medical Society. 59
What Next?..... 60
Endowment of McGill Medical Faculty..... 123
Who is he?..... 123
Canada Medical Association..... 124
Militia Surgeons..... 124
The Canada Sanitary Association 125
The Quebec Meeting..... 178
L'Ecole de Medicine et de Chirurgie..... 180
The Provincial Medical Board... 181
Our Medical Schools..... 183
Quadruplets..... 187
M. Souvelle 187
The Homewood Retreat..... 187
The Study of Anatomy..... 248
Provincial License Examination. 249
The Harvard Centennial..... 251
The Halifax Abortion Case..... 252
Doctors' Signs..... 312
Motor Cerebral Localization 313
Undergraduates' Dinner..... 316
The School Dinners..... 318
London Sanitary Convention 318
The University Question..... 373
Perineal Sutures..... 375
Dispensing Poisons..... 376
The Spirometer Case..... 337
Typhlitis and Peri Typhlitis..... 487
Sale of Poisons..... 441
Provincial Matriculation in Medicine..... 442
The Study of Anatomy..... 504
Proposed Sanitary Bureau..... 506
The Term "Plucking"..... 511
Treatment of Diphtheria..... 563
McGill University Convocation.. 565
Charges against Victoria College. 572
Atropine in Opium Poisoning.... 630
Provincial Medical Board 631
Montreal General Hospital..... 631
The Practical Home Physician.. 632
Carbolic Acid in Typhoid..... 633
Hypodermic Injections of Chloroform..... 633
Contagious Diseases and Travelling..... 699
Constitutional Treatment of Tuberculosis of Joints..... 701
Antipyrin, Action of..... 750
Carbuncle, Treatment of..... 761
Volunteer Medical Officers..... 761
Pathologists, An Opportunity for American..... 762
Cholera..... 763
Surgery Extraordinary..... 764
Canada Medical Association..... 764
Pharmaceutical Association, P.Q 765
Elbow, Reduction of Dislocation of. 95
Electrolysis in Nævus of the Face... 87
Empyema, Case of..... 449
" Treated by Operation.... 696
" Dr. Cabot on Treatment of 308

PAGE

Endocarditis, Ulcerative, Case of.... 349
Epilepsy, Nitroglycerine in..... 43
Epilepsy, Treatment of..... 564
Epilepsy, Nitroglycerine in..... 691
Epitheloma of Tongue, Case of..... 352
Erysipelas, Iodoform in..... 666
" of Face, Treatment of... 99
" Local Treatment of..... 766
Ether in Obstetrics..... 423
" Case of Death from 542
Examination, Preliminary, P.Q 447
Excision of Tongue..... 6
" of Knee-joint..... 278
Exomphalos, Radical Cure of..... 474
Exophthalmic Goitre..... 160
Extirpation of Cancerous Uterus.... 227

Faradization for Strangulated Hernia..... 667
Femoral Artery. Wound of..... 300
Femur, Fracture of Neck of..... 282
" Fracture of..... 687
Fenwick, G. E., M.D.:
Ligature of Axillary Artery..... 238
On Imperforate Anus..... 115
Fever, Catheter..... 465
" Exchange of Gases in..... 562
" Puerperal, Cases of..... 456
" Puerperal 548
" Puerperal, Prevention of..... 695
Fibroid Mucous, Case of..... 174
" Uterine..... 346
Fibroids complicating Pregnancy.... 385
Fibroid, Uterine 104
" " 35
Fibro-myxoma, Case of..... 122
Fleshmole Placenta, Case of..... 429
Flies, Ill-doings of..... 366
Fœtus, Anencephalic..... 602
Foods for Infants..... 436
Foot, Amputation in Middle of..... 671
Forceps in Breech-presentations..... 751
Fractures, Treatment by Plaster 280

Gangrene of Bowel..... 110
" Senile, Amputation in 472
" of Limbs in Typhoid Fever 615
Gardner, Wm., M.D.:
Case of Uterine Cancer..... 347
Case of Elephantiasis of Labia.. 432
On Cystitis..... 641
Retrospect of Obstetrics and Gynæcology .....14, 218, 408 and 585
Gastrostomy 212
" in Olden Times 611
Goitre, Circular..... 672
" Exophthalmic, Lecture on .. 705
Goodwin, Edwin, M.B., on Fibroids in Pregnancy..... 385
Graham, J. E., M.D.:
On Leprosy..... 152
" " 114, 213
On Anæmia 696
Graves' Disease, Lecture on 705
Groves, Dr., on Empyema..... 696

Hæmatocele, Pelvic, Case of..... 273
Hæmoglobinuria, Case of..... 545
Hæmorrhage, Uterine, Hydrastis in . 451
Heart, Non-valvular Dilatation and Hypertrophy of..... 426
Hemorrhage, Menstrual. Duration of 753
Hernia Diverticula Intestinalis..... 673
" Femoral, Case of..... 117
" Femoral, Case of..... 321
Hingston, W. H., M.D., on Talipes .. 484

	PAGE
Hodgkin's Disease	101
Hog, Pneumo-enteritis of the	429
Hordeolum, Treatment of	96
Hot Water after Operations	224
Howard, Dr. Henry, on Division of Labor, etc	295
Hydrarthrosis	120
Hydrastis Canadensis in Hemorrhage	415
Hyoscyamine in Mental Diseases	113
Hyperidrosis Lateralis, Case of	534
Ice in Mastitis	425
Ignipuncture in Uterine Disease	591
Imperforate Anus, with Fœcal Fistula	115
Infant Foods	436
Inflation of Lungs by Abdominal and Thoracic Traction	111
Innominate Artery, Ligature of	99
Intestine, Resection of	118
" Recent Operations on the	653
" Resection of Cancer of	675
Introductory Address, McGill Medical Faculty	129
Iodoform, Lecture on	394
Iodoform in Erysipelas	666
Iodoform in Perineal Laceration	24
Kennedy, R. A., M.D., Presidential Address	242
Kidney, Floating: Treatment by Fixation	99
Knee-joint, Excision of	278
Koch, Dinner to Prof	677
Labia, Elephantiasis of	432
Labor, Third Stage of	693
Lacerations of Perineum—iodoform treatment	24
Lacerations of the Cervix	27
" Operations for	599
Larynx, Extirpation of	674
Leprosy in New Brunswick..114, 152,	213
Letter, Berlin	721
Listerism in London	211
Liver, Amyloid	103
Liver, Scirrhus of	546
" Cancer of	300
London Letter, "T. G. R."	325
Lupus-non-exedens	85
Lympho-sarcoma of Bronchial Glands	102
Major, Geo. W., M.D.:	
On Pharyngo-Nasal Growths	122
On Exophthalmic Goitre	160
Maggots in the Ear	260
March, J. E., M.D., on Plaster of Paris Dressing	79
Marriage and Mitral Stenosis	617
Mastitis Treated with Ice	425
Medico-Chirurgical Society of Montreal	741
Meningitis, Cerebro-spinal	696
Menopause, Metrorrhagia at the	591
Mental Diseases, Hyoscyamine in	113
Metcalf, Dr., on Hyoscyamine	113
Methylene, Bichloride of	536
Metria	408
Metrorrhagia at the Menopause	591
Milk, To Check Secretion of	503
Mitral Disease, Cases of	333, 337
Muscle, Transplantation of, in Man	94
Myoma, Uterine, Treatment of	218
" Uterine, Treatment of	28
McDonald, J. A., M.D., on Calculus in Kidney	524
McDonald, Dr., on Paracentesis Pericardii	118
McDonnell, Richard, M.D., on Testis in Perinæo	43
McLean and Duncan, Drs., Cases in Practice	271
Murmur, Heart, heard in Utero	766
Nævi, Treatment of	92
Nævus, Treatment of	476
" of Face Treated by Electrolysis	87
Nerves, Suture of, after Division	89
Neuralgia, Brachial	355
Neuroma on Brachial Nerve	355
Nitro-glycerine in Epilepsy	43
OBITUARY:	
Dr. James A. Sewell	188
" E. H. Trudel	253
" Marion Sims	254
" Wm. McGill	254
" Hilton Fagge	319
John L. Howey	319
Dr. Calvin Ellis	378
" John Reddy	444
" Alex. Jamieson	445
" L. P. Yandell	573
" Caspar Wistar	573
George Engelmans	573
Dr. James J. Dickinson	635
Prof. S. D. Gross	636
Obstetrics, Cases of	165
" Dr. Rodger's Case of	296
" Ether in	423
Ogston's Operation	673
Oldwright, Dr., on Fibro-myoma	122
Oophorectomy, Cases of	173
Operations, Early and Late in Tumors	307
Ophthalmic Practice, Common Errors in	147
Opium as an Aid to Surgery	663
Os Uteri, Corroding Ulcer of	585
Osler, Wm., M.D.:	
Aneurism of Anterior Cerebral	34
Hodgkin's Disease	101
Some Features in Chr. Bright's Disease	121
Case of Hæmoglobinuria	546
On Caries of Skull	351
Osteomyelitis, Micro-organism of	616
Ovarian Cysts in an Infant	302
Ovariotomy in London Hospitals	275
" Lecture on	593
" in Billroth's Klinik	4
Papillomata, Post-laryngeal	11
Paracentesis Pericardii, Case of	118
Parlysis Agitans	601
Pasteur, M., on Etiology of Cholera	371
Patella, Treatment of Fracture of	282
Pericardium, Paracentesis of	118
Pessary-ring, Removal of	759
Pharyngo-nasal Growths	122
Paraldehyde	539
Phthisis, Contagiousness of	498
Pigmentary Degeneration of Retina	120, 193
Plaster of Paris Dressing	79
Playter, Dr., on Diet as a Therapeutic Agent	109
Pleuritic Effusion, Absorption of	363
Pneumonia, is it Infectious?	65
" Origin and Nature of	753

PAGE

Polypus, Uterine Fibroid 35
Pregnancy, Fibroids in 385
Preliminary Examination, P.Q. 447
Premature Labor for Puerperal Albuminuria 571
Proudfoot, A., M.D., on Color-Blindness 122
Pulmonary Artery, Perforation of ... 352
Quinine, Danger of Large Doses of .. 540

Rectum, Etherization by the 621
" Anæsthesia by the 661
Reed, T. D., M.D. Case of Hyperidrosis 534
Remedies, Good, Out of Fashion 51
Retina, Pigmentary Degeneration of 120, 193
Retroflexion and Retroversion of Uterus 116

REVIEWS:

Manual of Gynecology. Drs. Hart and Barbour 30
Diseases of Women. Dr. Heinrich Fritsch 31
Manuel des Injections Sous-Cutanees. M. Bonneville ... 31
Therapeutic Handbook of the United States Pharmacopœia 32
Transactions American Medical Association 33
The Essentials of Pathology. Dr. D. T. Gilman 100
A History of Tuberculosis. Dr. Eric E. Sattlar 100
A New School Physiology. Dr. Richard J. Dunglison 101
A Treatise on Insanity in its Medical Relations. Dr. W. A. Hammond 170
Medical Essays. Oliver Wendell Holmes 171
The Microscope and Its Revelations. William B. Carpenter 172
A Treatise on Diseases of the Eye. J. Sœlberg Wells 231
Excision of the Knee-joint. Dr. Geo. E. Fenwick 232
Gout in Its Protean Aspects. Dr. J. Milner Fothergill 233
The Untoward Effect of Drugs. Dr. L. Lewin 234
Pocket-book of Physical Diagnosis—Heart and Lungs. Dr. Edward T. Bruen 235
The Practitioners' Ready-Reference Book. Dr. Richard J. Dunglison 235
Transfusion: Its History, Indications and Modes of Application. Chas. E. Jennings ... 236
Text-book of Pathological Anatomy and Pathogenesis. Ernest Ziegler 290
What is to do first in Accidents and Emergencies. Dr. Chas. W. Dulles 291
Treatment of Wounds as Based on Evolutionary Laws. Dr. Pitfield Mitchell 291
The Elements of Histology. Dr. E. Klein 292
The Roller-bandage. Dr. W. B. Hopkins 293

PAGE

Hand-book of Electro-Therapeutics. Dr. L. Putzel 340
Practical Treatise on Materia Medica and Therapeutics. Dr. R. Bartholow 341
Medical Students' Manual of Chemistry. Dr. R. A. Williams. 342
The Treatment of Wounds. Dr. L. J. Pilcher 343
The International Encyclopedia of Surgery. John Ashurst, Jr 344
Descriptive and Surgical Anatomy. Dr. Henry Gray 344
Treatment of Diseases of Infancy and Childhood. Dr, C. H. Goodwin 418
Pathology and Treatment of Venereal Diseases. Drs. Bumstead and Taylor 419
Treatise on the Uses of Electricity. Drs. Beard and Rockwell 420
Chemistry, General and Medical. Dr. John Attfield 421
A Manual of Pathology. Dr. Joseph Coates 421
Types of Insanity. Dr. A. McL. Hamilton 422
Operative Treatment of Intra-Thoracic Effusion. Dr. N. Porritt 478
Bedside Urine-testing. Dr. G. Oliver 479
Students' Manual of Nose and Throat. J. M. D. Kitchen ... 480
Typhoid Fever in Victoria. Dr. J. W. Barrett 480
Chemistry, Inorganic and Organic. Prof. Bloxam 481
A System of Oral Surgery. Dr. J. E. Garretson 481
A Treatise on Pharmacy. Prof. G. Parrish 543
Manual of Practical Hygiene. Dr. E. A. Parkes 544
Surgical Applied Anatomy. Dr. Fred. Treves 544
Principles and Practice of Surgery. Dr. H. Agnew 596
Eczema and Its Management. Dr, L. D. Bulkley 597
Treatise on Bright's Disease. Dr. H. B. Millard 679
Pathology and Treatment of Gonorrhœa. Dr, J. L. Milton .. 682
San Remo, Climatically and Medically Considered. Dr. A. H, Hassall 683
A Treatise on Syphilis in Infants. M. P. Diday 685
Veterinary Medicine and Surgery. F. O. Kirby 685
A Manual of Pratical Pathology. Dr. G. S. Woodhead 686
Elements of Practical Medicine. Dr. A. H. Carter 732
The Dissectors' Manual. By Clarke and Lockwood 733
Diseases and Injuries of the Eye and Eyelids. By Louis H. Tosswill, M.B 734
Diseases of the Rectum and Anus. By Dr. Charles B. Kelsey 735
Influence of the Mind upon the Body. By D. H. Tuke. M.D. 736

PAGE

The Field of Disease. By Benjamin W. Richardson, M.D.... 738
Study of the Bladder during Parturition. By J. H. Croom, M.D 739
A Manual of Obstetrics. By A. F. A. King, M.D..... 740
Rheumatism in Childhood..... 502
" Acute 551
Rickets, Prevalence of, in Glasgow.. 613
Roddick, T. G., M.D., on Varicocele. 648
Rodger, T. A., M.D. Case of Obstetrics 296
Roseburgh, Dr., on Boracic Acid in Ear Diseases..... 697
Ross, George, M.D.:
Case of Non-valvular Hypertrophy 426
Valedictory Address..... 573

Saddle-crutch 494
Salicylic Acid, Administration of.... 537
Sarcoma of Lumbar Glands, Case of. 534
Sawdust, Carbolized, as a Dressing .. 289
Sciatica, with Loss of Sensation..... 719
Scott, J. G., M.D., on Empyema..... 449
Septicæmia, Puerperal, Iodoform in. 414
Sexual Excitement and Torture..... 496
Sheard, Dr., on Gangrene of Bowel . 110
Shepherd, F. J., M.D.:
Retrospect of Surgery—89, 278, 465, 653.
Case of Neuroma..... 355
Sarcoma of Lumbar Glands..... 354
Wound of Palmar Arch..... 38
On Epithelioma of Tongue..... 352
Shepherd, F. J., M.D., on Antiseptic Treatment of Wounds..... 712
Smith, A. L., M.D., on Puerperal Eclampsia..... 349

SOCIETY PROCEEDINGS:

Medico-Chirurgical Society of Montreal—34, 101, 173, 237, 294, 346, 423, 483, 545, 598 and 687
Ottawa Medico-Chirurgical Society 247, 359
New Brunswick Medical Society 44
McGill Medical Society..... 493
Ontario Medical Association 691
Spina Bifida, New Operation for..... 310
Spine, Injury to, Case of..... 694
Spleen, Extirpation of..... 672
" Primary Sarcoma of..... 672
" Fœtal, Preventing Delivery. 624
Stewart, Dr. James:
Letters 1
On Tabes Dorsalis 356
On Iodoform..... 394
Retrospect of Pharmacology and Therapeutics 536
Stewart, James, M.D., on Exophthalmic Goitre..... 705
Stomach, Fibroid Disease of..... 302
Stomach, Dilatation of Cardiac Orifice 663
Strasburg, Letter from..... 528
Sugar, as a Dressing..... 289
Syphilitic Lesions of Os and Cervix Uteri..... 175

PAGE

Tabes Dorsalis, Early Symptoms of.. 356
Tait, Lawson. Operation 36
Tait's, Lawson Operation, Case of ... 359
Talipes, Certain Forms of..... 484
Tampons, Medicated, for Displacements 586
Teeth, Transplantation of..... 671
Teeth, Syphilitic 741
Testis, Tuberculosis of the..... 757
Testicle—in Perineo..... 43
Thorburn, Dr., on Spinal Injury..... 694
Thyroid Cyst, Acute, Case of 160
" Gland, Removal of..... 1
" " " 367
Throat, To Remove Foreign Bodies from..... 503
Tic Douloureux, Diagnosis of 370
Tobacco as an Antizymotic 767
Tobin, Dr., on Pigmentary Degeneration of Retina.....120, 192
Tongue, Excision of 6
" Epithelioma, Case of 352
Tooth, Curious Malposition of a..... 869
Tracheotomy, by Dr. Alloway..... 104
Transplantation of Muscle in Man.. 94
Trenholme, F. H., M.D. Cases of Oophorectomy 173
Tubercular Disease and Post Laryngeal Papillomata..... 11
Tuberculosis, Transmission of..... 750
Tumors, Malignant, converted into Innocent 398
Tumor, Sarcomatous, of Thigh..... 547

Ulcerative Endocarditis, Case of.... 349
Urethral Stricture, Treatment of.... 245
Urethritis, Chronic, Treatment of.... 477
Uterine Myoma, Treatment of....28, 218
" Treatment, Technique of.... 416
Uterus, Retroflexion and Retroversion of..... 116
" Cancerous, Extirpation of.. 227
Ureter, Temporary Closure of an.... 756

Valedictory Address..... 513
Valves, Disease of Aortic, Mitral and Tricuspid..... 426
Varicocele, Treatment of..... 648
Veins, Closure of Wounds of..... 287
Venom, Serpent, in Tetanus..... 435
Vertebræ, Traumatic Aneurism of.. 618
" Dislocation of Cervical... 668
Vienna Letter..... 1
Vineberg, H. N., M.D., on Puerperal Albuminuria 577
Vulvitis, Apthous, in Children..... 288

Warts, Treatment by Carbolic Acid. 98
Water, Hot, Therapeutic Use of 433
White Swelling, Treatment of 279
Wilkins, Geo., M.D., on Pneumonia. 65
Workman, Jos,, M.D., Introductory Address 129
Worthington, Dr.:
On Cerebro Spinal Meningitis ... 696
On Retroflexion of Uterus..... 116
Wound of Palmar Arch..... 38
Wounds, Lecture on Treatment of... 712
" Antiseptic Treatment of ... 712
Wright, Adam, M.D., on Puerperal Fever..... 695

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CURRIE, J. Z., M.D.,
DORLAND, JAMES, M.D.,
DUNCAN, G. M., M.D.,
DUNCAN, W. J., M.D.,
GARDNER, WM., M.D.,
GOODMAN, E., M.D.,
GRAHAM, J. E., M.D.,
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MAJOR, GEO. W., M.D.,
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MILLS, T. W., M.D.,
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REED, T. D., M.D.,
RODDICK, T. G., M.D.,
ROSS, GEO., M.D.,
SCOTT, J. G., M.D.,
SHEPHERD, F. J., M.D.,
STEWART, JAMES, M.D.,
TOBIN, W., M.D.,
VINEBERG, H. N., M.D.,
WILKINS, GEORGE, M.D.,
WORKMAN, JOS., M.D.

CANADA

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Original Communications.

VIENNA LETTER.

(From our Special Correspondent.)

VIENNA, June 30, 1883.

THE REMOVAL OF ENLARGED THYROID GLANDS.

There is probably no operation in surgery that is attended with so much difficulty as the removal of an enlarged thyroid gland. No matter what the size and histological characters of the tumor are, its removal is always attended by great difficulty and considerable danger.

The operation, as performed at present, is, however, after all, a fairly successful one. During the last five years Billroth has performed this operation 68 times. The mortality was only 7½ per cent. In the previous five years his mortality was 29 per cent., and 36 per cent. in the five years before that. This great reduction in the death-rate he accounts for thus—1st, The employment of the strictest antiseptic precautions, by which septicæmia, which formerly headed the list as the cause of death, is banished; 2nd, Improved method of operating. During the last few weeks Billroth has lost three cases; these cases are not included in the 68 previously mentioned. In one, death took place suddenly on the operating table, immediately after the completion of the operation. The cause of death in this case was supposed to be the entrance of air into the veins. In the second case, the death was directly due to collapse of the trachea five days after the operation. The patient had tetany, and to

this the death was attributed previous to the post-mortem. In the third case, death was directly due to tetany.

In a previous letter reference was made to the remarkable fact of the frequent occurrence of tetany after this operation, especially in women. In the last 73 operations in the General Hospital here, there were twelve cases of tetany, eight of which proved fatal. Even those patients who do not die from tetany, appear seldom to recover completely from it. The writer has seen two cases of very well marked tetany in women following the removal of enlarged thyroids, performed three years previously. There has not been, as yet, any satisfactory explanation given of this complication. Whether it is due to injury of the recurrent laryngeal or sympathetic nerves has not been proved. Billroth considers that, at least in his cases, irritation of the recurrent laryngeal can have no influence in bringing it about, as he is always extremely cautious in his dealings with this nerve. Very recent investigations of Dr. Weiss, which will be published shortly, prove, he thinks, that in tetany there are changes in the anterior horns of grey matter of the cervical spine.

In the surgical cases of tetany, there is no remedy that seems even to mitigate the symptoms. Billroth has long ago given up performing this operation for the simple removal of a deformity. He never performs the operation now unless the life of the patient is directly in danger from pressure on the trachea.

As the method of operating is so very important, and as there is no description of it, as far as I am aware, in any of the numerous English surgical text-books, I will give the different steps of the operation as always practiced by Billroth. It is to him and Kocher that we owe the modern operation.

The incision is made along the internal border of the sterno-mastoid muscle, its length depending upon the size of the tumor. If it is very large, it is sometimes necessary to carry the incision in a semi-lunar direction to the lower end of the opposite sterno-mastoid. The fascia and omohyoid are cut through. The dissection is carefully made until the capsule of the gland is fully exposed. Here begins the first difficulty in the operation. The capsule is composed of from three to eight or more layers, and

it is always advisable to cut through each layer until the last one is reached, otherwise there is considerable difficulty in enucleating the tumor. Between the most internal layer of the capsule and the structure of the gland there is a very rich plexus of veins. The internal layer should not on this account be cut through, otherwise serious and uncontrollable hæmorrhage sets in. Should such an accident happen, the only hope of saving the patient's life is to remove the gland as rapidly as possible. After the different layers are cut through until the most internal is reached, the superior thyroid artery is double-ligatured and cut. The next step of the operation is the ligaturing and cutting through of the inferior thyroid artery. This is the most difficult part of the operation—not that this vessel presents any mechanical difficulty in its tying, but that in looking for it, and especially in tying it, there is great danger of wounding the recurrent laryngeal nerve. The artery and the nerve are so intimately connected that it requires the greatest possible care to avoid wounding the latter. The artery, before entering the gland, usually divides into three or four branches. Sometimes the nerve lies in front and sometimes behind the arterial branches. Often, however, it is so intertwined among the arterial twigs that it requires great care to isolate it without injury. If the artery is tied before its division, on removing the gland the nerve will be torn across. The best way to proceed is to find the nerve at the lowest part of the incision, and follow it up until it disappears in the larynx. It can easily be found in the sulcus, between the trachea and œsophagus, and it should be carefully isolated from the sulcus to the thyroid cartilage. The branches, and not the main artery, should be tied. It is necessary, also, to tie the middle thyroid vein. The next step in the operation is the enucleation of the tumor. The operation is completed by removing the tumor from the trachea, and unless this is performed very carefully it is attended by considerable danger. It is necessary to raise the tumor in cutting it away from the trachea, and in doing so the latter becomes bent on itself and the patient is in imminent danger of being suffocated. When there are symptoms of the latter, the tumor should be dropped

back and the trachea allowed to resume its natural position. It is advisable to work for not more than ten seconds at a time. Several deaths are reported from this cause.

At the meeting of German surgeons in April last, Kocher of Berne, who has had a very extensive experience in the removal of enlarged thyroids, said that when the operation was performed on young people, it was apt to be followed five or six years afterwards by a condition resembling cretinism. In these cases the patients complain of a feeling of weakness and coldness. There is slowness of thought, speech and movement, swelling of the hands, feet, abdomen and face, giving the patient the appearance of one affected with Bright's disease. In the discussion which followed the reading of Kocher's paper, none of the surgeons who took part in it had seen any of the symptoms described. This is also Billroth's experience.

ANTISEPTIC PRECAUTIONS TAKEN IN OVARIOTOMY IN BILLROTH'S KLINIK.

In the performing of ovariotomy, or any abdominal section, Prof. Billroth takes the utmost care that in every detail of the operation the strictest antiseptic means are employed. All abdominal operations are performed in a special room. This room is very frequently cleansed in the most thorough manner, and during the operation the temperature is kept at 20°C. The day previous to operating the patient gets a warm bath, and on the morning of the operation the bowels are emptied by injections. The abdomen is thoroughly washed twenty-four hours previous to the operation, and over night it is covered with compresses soaked in a two per cent. carbolic acid solution. Immediately before operating, the bladder is emptied by an assistant, who does not take any part in the operation afterwards. The vagina is washed out with a one per cent. carbolic acid solution, and afterwards filled with strips of iodoform gauze, the object of this being that, should, during the operation, any communication be made between the vagina and abdominal cavity, the danger of septicity will be much diminished. For an hour previous to commencing the operation, a five per cent. spray is kept going

in the room. The spray is, however, not used after the abdominal cavity is opened.

The sponges used in this, and, in fact, in all operations, are cleaned, bleached, and made antiseptic in the following manner:

1. They are cleaned from sand by being pressed between the folds of a towel; they are then repeatedly washed in lukewarm water which has been previously boiled. The water should not be hot, as it causes a shrinking.

2. In order to bleach them, they are put into a solution of the permanganate of potash (1–1,000) for 24 hours, and afterwards well washed in lukewarm water. They are then put into a solution of subsulphite of sodium (1–100), to which has been added a fifth of the quantity of a solution of hydro-chloric acid (8–100). In this mixture they are kept for a few minutes only. After their removal they are again washed in water, and are finally left for three days in cold water, which is frequently changed.

3. To render the sponges antiseptic, they are first placed in lukewarm water, where they are left from three to five days. The water should be changed daily. They are afterwards placed in a five per cent. solution of carbolic acid, where they are left until required. The solution should be changed every 14 days. Sponges are never used unless they have, at least, lain 14 days in this solution. Fresh or dry sponges are never used.

Care should be taken that a sponge is not left exposed to the air for any length of time during an operation. After operations, where the wound is fresh, the sponges, before being put back in the five per cent. carbolic acid solution, are kept in water for a couple of days to remove the blood coagula, and, for the removal of fat, in a soda solution for a few hours. Sponges that have been used in putrid wounds are burnt. In ovariotomy, the sponges are removed from the 5 per cent. solution, well pressed, and placed in a 1 per cent. warm solution of carbolic acid.

The operator and his assistants wear, during the operation, freshly-washed linen coats, and which, just previous to commencing work, have been exposed for some minutes to the carbolic acid spray. Bleeding vessels are tied with antiseptic silk. The

pedicle is also tied with antiseptic silk. The external dressings consist of a strip of iodoform gauze, which is placed in direct contact with the abdominal wound, several layers of carbolic acid gauze, and antiseptic cotton.

EXCISION OF THE TONGUE.

By G. M. DUNCAN, M.D.

(Read before the New Brunswick Medical Society, July 18, 1883.)

Let me call your attention for a few moments to a case of excision of the tongue. Numerous methods of operating have been proposed, some of which, as, for instance, those of Syme and Regnoli, should be mentioned only to be classed as relics of a past and barbarous surgery. They are accompanied by much hæmorrhage, are very dangerous, and produce horrible mutilation. Simpler and safer methods are those of Paget and Barwell, but simpler and safer still that of Whitehead, who removes the entire organ, from the epiglottis to the os hyoides, through the mouth, by means of a pair of scissors, as reported in the *Lancet*, Oct. 22nd, 1881. In order to successfully remove the tongue without skilled assistance, a very important question to be decided is—What is the best and safest method of excision, taking into consideration the two special dangers of the operation, viz., hæmorrhage and septic complications? No one method will suit all cases. Each must be decided by its peculiarities. Experience has proved that removal of the tongue by the knife, as compared with the wire ecraseur, is not only more liable to be followed by hæmorrhage, but also by septicæmia. The largest percentage of fatality, however, has resulted from the galvanocautery ecraseur. The slough which follows is most offensive, and the period of convalescence prolonged. The different methods and their merits are fully described in works on surgery, or in the journals of the day. That adopted in the following case was a combination of scissors and wire ecraseur:—

Miss M. E., æt. 28. No history of cancer in the family. The trouble in the tongue began about four years ago. The tongue was felt to be sore, especially during deglutition, and

increased salivation was noticed. After a time it was observed that with each menstruation the tongue swelled, and that then it was much irritated by the sharp edge of a decaying 2nd left molar, which finally gave rise to a sore. With the menstrual interval came a period of ease. Ultimately there was constant pain and profuse salivation. The sore increased in size, and felt like a hard lump, painful on pressure. In the autumn of 1881 she consulted a doctor, who broke the tooth in extracting it, and burnt the sore with caustic. The caustic was applied frequently till the end of March, 1882, when, owing to the increasing size of the sore and the almost unendurable pain produced by the caustic, she consulted me. Examination showed a swollen tongue, with an oval, raised, hard, very painful tumor on the middle of the left edge, extending towards the raphe, but not into the right half. Diagnosis, *scirrhus*. A lotion of Potassium Chlorate and Fld. Ext. Arbor Vitæ was given, with instructions to report in a fortnight. On her next visit the swelling had subsided, and there was less pain. The lump seemed smaller. The stump of the offending tooth was then extracted, and the lotion continued. No improvement followed. Excision was advised and agreed to, and the day named. Some friends officiously advised her people to send her to Halifax (of all places in the world). Dr. Slayter of that city confirmed the diagnosis, and, assisted by Dr. Turner, excised the *lump*. The *modus operandi* I know nothing of, save that it was accompanied by excessive hæmorrhage. Less than two months after the Halifax operation, there being sharp pains in the cicatrix, darting along to the throat and ear, she consulted me a second time. A firm lump, size of a very large marble, extended from the cicatrix into the right half of the tongue, the point being turned to the left. No enlarged glands were detected. The short lapse of time between removal and reappearance of the disease seems to indicate that a clean sweep had not been made. To remove a part of the tongue and to leave behind a diseased portion is a grave mistake. Partial excisions for cancer of the tongue should *never* be practised.

Of course I advised removal, and she very heroically consented. On the 25th of August last, assisted by two students,

except that it was less painful. As in the case of the tongue at each menstruation, there was an increase in size and pain, both gradually subsiding afterwards. Under the constant dread of its being cancer, her health began to suffer, and on June 25th it was removed.

After chloroformization, an incision, similar to that made in ligature of the lingual artery, was made from about one inch below and to the outside of the symphysis menti to a point directly over the os hyoides and thence to the angle of the lower maxilla. This formed the lower boundary of the tumor. From the centre of this, and at right angles to it, a second incision was made to the edge of the bone. The fascia, platysma and fat being divided and the flaps dissected up, a very firm lump, hard as cartilage, and nodular, was exposed. This was seized by a tenaculum and separated from below, exposing the hyoid bone and the mylo-hyoid, hyoglossus and digastricus muscles, and the submaxillary gland. The gland was indurated and knotty. It was therefore cleaned away from the facial artery, the submaxillary branches being cut and twisted. The tumor and gland were then separated from the edge of the jaw, to which the former was closely attached. The mylo-hyoid was drawn aside by a blunt hook and the deep portion of the gland dissected out, and the whole removed. There was no hæmorrhage of any moment, and no ligatures were required. The wound was well sponged out with a 1 to 40 carbolic lotion, which was used throughout to cleanse the sponges. After all oozing had ceased, the edges were brought together by seven sutures and a dressing of Chloral Hydrate ʒj to water Oj applied. There was considerable vomiting from about the middle of the operation till next morning. A hypodermic of Morphiæ Sulph. gr. ⅓ gave some sleep, and the nausea and vomiting gradually disappeared towards morning. The catheter was required three times. Iced milk, cocoa, and brandy and water were freely used at first, and subsequently beef-tea. The sutures were removed on the sixth day. The wound healed kindly and uninterruptedly, and on the eleventh day she was sent home.

Examination under the microscope showed the tumor to be scirrhus.

THE VALUE OF POST-LARYNGEAL PAPILLOMATA AS A MEANS OF DIAGNOSIS IN TUBERCULAR DISEASE.

By GEO. W. MAJOR, B.A., M.D.,

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(*Abstract of a paper read at the Fifth Annual Congress of the American Laryngological Association, at New York, May 23rd*, 1883.)

After carefully and systematically observing, during the past five years, the laryngeal appearances of a large number of tuberculous cases, I have arrived at a few conclusions concerning some important indications heretofore practically unrecognized. For the sake of convenience and accuracy alike, I have divided the neoplasms about to be considered into two forms.

I.—The *Velvety*.

II.—The *Filamentous*, or *Feathery;* the latter an advanced stage of the former.

These papillomata, to be of any diagnostic value, must occupy the laryngeal surface of the meso-arytenoid fold. They are of a greyish-white color, and abundantly supplied with moisture.

The *velvety* growth (so called from its resemblance to the pile of velvet), best seen when the arytenoids are widely separated on full inspiration, is not necessarily an indication of active pulmonary tuberculosis, but it is evidence of a decided tuberculous tendency. This form of excrescence varies much in degree from a mere line to an almost shelf-like prominence, running transversely across the space, and its advance in development may fairly be taken as a standard of the patient's state. In a stout and robust man, I have more than once, on inquiry, found a family history of phthisis, where the only suspicion lay in the presence of a very rudimentary ridge. The extensive opportunities afforded by my clinique at the Montreal General Hospital, as well as by a numerous class of such cases in private practice, have led me to place the greatest possible value on these *velvety* developments (when present), not only as a means

of diagnosis and prognosis, but more particularly as a *means of anticipating* a pulmonary tuberculosis, of the onset of which we should be otherwise ignorant. In such cases a climatic change will actually prevent what it could later but feebly hold in abeyance. Of this form, in various stages of development, I have recorded some seventy cases.

The *Filamentous* or *Feathery* form varies in size and extent, sometimes reaching 3 millimetres in length, floating in the column of air, interfering with proper voice production, causing an aggravating cough, holding secretions and debris in its fibres, and giving rise, in breathing, to a fine crepitant, crackling sound resembling the bursting of minute bubbles. This advanced state occurs only in reduced health; though we may not detect tubercle by any physical signs, *it is sure to be present.* It may not have advanced to softening, or even to extensive deposits, but it is there. My experience of this class (filamentous) is based on 17 cases, all of which were particularly rapid in their course, and all fatal; so that, as to prognosis, an advanced filamentous growth is markedly unfavorable.

In so far as my knowledge goes, this last description occurs in about 9 per cent. of all cases; it probably does much oftener, as but a few of all cases are submitted to laryngoscopic investigation until ulceration has taken place, and then no trace of these neoplasms are found. These filamentous bodies ulcerate usually as lung softening sets in, and present themselves in cases where other laryngeal signs are absent.

I do not remember a single instance of pyriform swelling of the arytenoids being associated with either form of papilloma; on the very contrary, the larynx presents an excessively attenuated, sharply defined appearance. These growths are only present *in some cases*, are as often present as any single laryngeal sign,—if we except, perhaps, pallor of the mucous surface, —and are, when present, of all known indications, *the most trustworthy.*

Why the region indicated should be the one selected by these developments, I do not attempt to explain. Does its incessant movement in respiration, a motion from birth to death all but

perpetual, decide the location? That they should occur on the mucous membrane covering the arytenoideus muscle—the muscle most early infiltrated with tubercle in laryngeal tuberculosis—seems more than a coincidence.

These few facts I offer with confidence, as a valuable supplement to the already recognized laryngeal signs of tuberculosis.

RADICAL CURE OF HYDROCELE BY THE INJECTION INTO THE SAC OF CARBOLIC ACID.

By J. M. JONAH, M.D., of Eastport, Maine, U.S.

Abstract of a paper read before the New Brunswick Medical Society, July 18, '83.

The reader of the paper first gives an interesting history of the treatment of hydrocele, describing the various methods which have been in vogue during the past century. He refers to the employment of iodine, but thinks that it is uncertain, and, in his experience has been followed by unfavorable results. In 1882 he began to use carbolic acid, as recommended some years ago by Dr. Levis of Philadelphia.

Dr. Jonah's first case is that of a young man whose hydrocele had been tapped no less than 38 times, and once injected with iodine. He removed on the last occasion eight ounces of straw-colored fluid, and threw into the sac 70 grains of the crystallized carbolic acid, held in solution by less than 10 per cent. of water. A sensation of warmth more than pain was experienced. The patient resumed work on the sixth day, and has had no return of the hydrocele.

The second case was that of a man of 54 years, who had been relieved of his "scrotal burden" about twenty times. No untoward event followed, and the patient was attending to business on the fourth day.

After reporting briefly a third case, Dr. Jonah brings his paper nearly to a close by describing the operation in Dr. Levis' own words, and we give the quotation in full:—

"For the purpose, crystallized carbolic acid is maintained in a liquid state by a five or ten per cent. addition of either water or glycerine. After the tapping of the sac, I inject the liquified

crystals of carbolic acid with a syringe having a nozzle sufficiently long and slender to reach entirely through the canula. The object of this special form of instrument is to place the injection entirely within the sac, without any reflow, which would irritate the skin of the scrotum, the fingers of the operator, and without the possibility of injecting it into the connective tissue between the skin and tunica vaginalis. Ninety grains is the maximum and thirty the minimum I have used. As soon as the scrotum is injected, it is freely manipulated by the fingers of the operator so as to diffuse the acid over the lining walls of the hydrocele. A sense of warmth is produced, which is quickly followed by a decided numbness, and the patient is at once able to walk about. I do not enforce rest until 24 hours, when intra-scrotal inflammation renders quietude agreeable or imperative. I have never been able to detect any toxic effects from the absorption of the acid, no general depression, no discoloration of the urine. I believe that the action of strong carbolic acid on surfaces secreting albuminous fluids is to seal them, and, as it were, to so shut them off from the system that absorption cannot readily take place. In a case of hydrocele complicated with a sarcomatous testicle, I had moderate suppuration."

QUARTERLY RETROSPECT OF OBSTETRICS AND GYNÆCOLOGY.

PREPARED BY WM. GARDNER, M.D.,

Professor of Gynecology, McGill University; Attending Physician to the University Dispensary for Diseases of Women; Physician to the Out-Patient Department, Montreal General Hospital.

NOTE.—*The translations are made expressly for this Journal.*

The Present Aspect of the Cæsarean Operation.—As our readers are doubtless all aware, the old Cæsarean operation has for the last five or six years, at least in continental Europe, been cast quite in the shade by the Porro operation, which three months ago had been performed about 110 times with a mortality of about 56 per cent. For a hundred years or more Cæsarean section, according to the old method, had been almost uniformly fatal in the lying-in hospitals of the Continent. Obstetricians

welcomed with great enthusiasm a procedure which immediately gave results so much superior to the old operation. But at the time alluded to antiseptic surgery was becoming popular, and its greatest triumphs were claimed to be in abdominal surgery.

A reaction is now taking place, especially in Germany, against an operation which, while it may save the life of mother and child, unsexes and mutilates the former by removing the ovaries and amputating the uterus at the cervix. It is an undoubted fact that recovery after the old operation was rendered almost a matter of luck by the gaping of the unsutured uterine wound, with escape of blood and lochial discharges into the abdominal cavity. Dr. H. J. Garrgues, Obstetric Surgeon to the New York Maternity Hospital, in a most admirable paper in the April, May and June (1883) numbers of the *American Jour. of Obstetrics*, eloquently and with great power advocates the reinstatement of the old operation to favor. Dr. Garrigues claims that if the Cæsarean section be done with all antiseptic precautions, if the uterine wound be closely and carefully sutured, and if certain other precautions be taken, it will be attended with as good results as the Porro operation, while it does not, like the latter, take away capacity for further procreation. The advocates of the Porro operation claim this latter result to be a strong point in favor of the operation, and say that it is desirable that a woman with the pelvic deformity or other condition which rendered the operation necessary, shall not again become pregnant. In answer to this latter argument, which I cannot here fully discuss, Dr. Garrigues makes the following remark: "How often do we find, even among poor people, the natural desire of offspring strongly developed? How often is a marriage unhappy because it is childless? How often is the married woman despised because she has no children? Who can tell of what he deprives humanity by producing artificial sterility?" In addition, it may be remarked, experience has demonstrated that when a woman has once passed safely through the Cæsarean operation, her chances are thereby proved to be comparatively good for recovery from a subsequent operation.

I append almost in full Dr. Garrigues' description of the opera-

tion. It is, I have no doubt, the best description of the best and most modern method, with all its details, to be found in the English or any other language. The best time for operating is as soon as labor pains have become strong and frequent.

"The first part of the operation is identical with that of ovariotomy. The bowels and the bladder having been emptied, and the pubes shaved off above the symphisis, the abdomen is washed with soap, ether, and a five per cent. solution of carbolic acid, and the vagina disinfected with the same solution. The operator, his assistants, as well as the instruments, sponges, ligatures and sutures, ought to be disinfected according to the principles of antiseptic surgery. The temperature of the room ought to be about 80°F. The patient is placed on her back on a long, narrow table covered with a mattress, quilts, or blankets, over which is spread a sheet. She ought to be warmly dressed. She is anæsthetized, which may be begun while she is yet in bed. If possible, one or two steam-spray producers, filled with a solution of chloride of zinc, salicylic acid, or diluted chlorine water, are directed over the field of operation. The operator stands to the right of the patient. Besides the one who attends to the anæsthesia, four assistants are desirable. The chief assistant is placed in front of the operator. One to the left has special care of the uterus. One to the right hands the instruments. One to the left of the chief assistant has particularly to attend to sponging. By percussion, the operator ascertains that no intestines are present between the uterus and the abdominal wall, or pushes them aside. The chief assistant presses the abdominal wall against the uterus. An incision is made in the median line through the skin and the linea alba from the umbilicus to three or four centimetres (an inch or an inch and a half) from the symphysis pubis. Bleeding is, if necessary, controlled by means of compression forceps. Next, the peritoneum is lifted up with a tenaculum, and a small opening made in it, through which a director is passed, and the membrane incised to the same length as the other tissues. The incision is extended as much upward to the left of the umbilicus as may be deemed necessary for the easy extraction of the child. If possible, a strong elastic tube

or solid rubber cord is passed by means of a uterine sound round the cervix, tied in a half knot, which is grasped with a compression forceps. Behind the compressed place, thick silk ligatures are passed round both ends and tied. If it is not possible to pass the tube while the uterus is *in situ*, the incision is extended far enough up to allow of its being turned out, as in Müller's operation, and then the tube is passed and, if possible, tied. The uterus may be helped out by pressure from the vagina, besides lifting its fundus through the abdominal wound. If the child is too low down, the tube is merely put loosely round the cervix, and tightened after the removal of the child. The chief assistant prevents the protrusion of intestines by holding the lips of the wound together, pressing them against the uterus, or by applying a flat sponge or a cloth dipped in a warm disinfectant.

An incision is then made in the median line of the uterus so as to avoid the fundus and the cervix, but long enough to allow the child to be withdrawn with ease, say 12 to 14 centimetres (4½ to 5½ inches). This incision is best begun with a convex-pointed bistoury, and continued with a probe-pointed. If the placenta is in the line of incision, it is cut, together with the uterine wall (Spiegelberg). If the operation is performed with the uterus *in situ*, the chief assistant hooks both his index fingers into the angles of the uterine wound, holding it pressed against the corresponding points of the abdominal incision. If it is performed outside of the body, the assistant to the left of the operator covers the uterus with a warm cloth and steadies it, and the abdomen behind the uterus is covered with disinfected gutta-percha tissue.

If the waters have not broken, the operator tears the bag in such a way as to prevent the escape of the waters, especially if they are decomposed, into the peritoneal cavity. The best way of doing this is by turning the patient on her side, as is done for ovariotomy in this city. The operator tears the bag in a place where he can seize the head, the breech, or the feet of the child. It is an advantage to get the head out first, because the contraction of the

uterus round the neck after the delivery of the body may be so great as to render its removal difficult, and necessitate an extension of the incision. As soon as the child is delivered, the cord is tied and cut, and the child given to a nurse or, preferably, a sixth assistant, who, if it be asphyxiated, uses proper remedies for its revival.

If there is no hemorrhage beyond the evacuation of the blood pressed out of the uterine tissue by retraction and contraction, and if the placenta is not expelled spontaneously, it is good to wait about five minutes before detaching the secundines. This is done deliberately and with great care, so as not to leave any part behind, which is best accomplished by removing the after-birth in one piece. Thereafter clots are turned out from the womb and its interior mopped all over with sponges, and a drachm of the fluid extract of ergot is injected hypodermically. If there is hemorrhage, the tube surrounding the cervix is made to contract by kneading, hot cloths, or faradization. If the hemorrhage persists, and is seen to come from the internal surface, the bleeding parts are swabbed with vinegar, diluted alcohol, tincture of iodine, or liq. ferri perchloridi.

If the hemorrhage is prevented by the constriction of the cervix and broad ligaments, but the uterus does not contract, the same procedures are used.

If the cut surfaces have such a shape as to be easily adapted to one another, sutures may now be passed without further preparation. If, on the contrary, they bulge out so as to oppose resistance to a thorough adaptation, the peritoneum ought to be dissected off to a distance of one centimetre (three-eighths of an inch), a slice of the muscular tissue with the adherent portion of the decidua cut off from either side, and the peritoneal flaps turned down over the cut surface. Beginning at the upper end, a row of uninterrupted sutures of strong carbolized silk are passed one centimetre from the edge through the peritoneum and muscular substance, but not including the decidua. The distance between two and two sutures ought to be from 1 to 1½ centimetres. The ends belonging to a suture are tied together as soon as it is passed, in order to

find those which belong together when they are to be tied. When all these deep sutures have been passed, the provisional knot is cut off from one, and that tied firmly, the chief assistant approaching the edges with two tenacula, and taking particular care to bring as much as possible of the serous surface of the peritoneum of both edges into contact. The same is repeated for every suture from one end of the incision to the other. Then superficial sutures of finer silk are passed midway between the two and two of the deep ones, at a distance af five millimetres (one-fifth of an inch) from the edge. They go only through the peritoneum and the nearest muscular tissue, and in tying them, particular care is taken to bring as large surfaces of peritoneum in contact as feasible. All sutures are cut short.

When all the sutures have been tied, the constrictor is cautiously removed from the cervix. If any hemorrhage should occur, the above-named hemostatics are to be repeated, to which now may be added intra-uterine injection of water so hot that the hand can just be held in it (110° to 115°F). When the hemorrhage is arrested, a finger-thick soft rubber tube with side holes, to which is sewed a thinner tube without such opening, is introduced into the uterus by sliding it over a uterine sound or metallic intra-uterine catheter. The abdominal cavity is cleansed, and the abdominal wound closed with deep silver and superficial silk sutures passed at about twice as large intervals as on the uterus. The deep ones comprise a narrow strip of the peritoneum; the superficial ones go only through the skin.

If, on account of entrance of decomposed amniotic fluid into the peritoneal cavity, or protracted labor, or other attempts at delivery, before Cæsarean section was resorted to, peritoneal complications are to be anticipated, it is better to insert between two sutures a finger-thick glass tube with side openings reaching down into the recto-vaginal pouch. In this is inserted a wire wound with carbolized cotton.

Dressing.—The patient having been carefully cleansed, a full Lister dressing is applied to the abdomen, cutting a hole for the drainage tube, if one has been introduced. The latter is covered with carbolized cotton, and protective tied around it. The geni-

tals and anus are covered with crumpled gauze dipped in a 1 to 40 solution of carbolic acid, and covered with a thick layer of antiseptic cotton (carbolized, salicylated, or impregnated with boracic acid) which extends up to the abdominal dressing, and is fastened to it with a binder.

After-Treatment.—The first indication is to stimulate the patient with external heat and alcoholic drinks. Iced champagne is the best of these, but sometimes small doses of coffee are better retained than anything else (Howitz). Pain is subdued by opiates, which also serve to keep the bowels quiet. After the patient has recovered from shock, she may have light liquid food. If the temperature rises, it is kept down by quinine, carbolic acid, and external dry cold administered by ice-water running through coils of rubber tubing, to be applied to the head and abdomen. Vomiting is combated by opiates, by hydrocyanic acid, bismuth, strychnia, creasote, tincture of iodine, carbonic acid, ice, counter-irritation in the cardia, etc. Peritonitis is treated with large doses of morphia; septicæmia with carbolic acid or salicylic acid, and quinine. A weak and frequent pulse due to anæmia and weakness of the heart calls for hypodermic injection of digitalis, camphor dissolved in ether, or transfusion.

In favorable cases, the abdominal dressing may remain undisturbed for a week. Then the superficial sutures are removed. The deep ones are left in a few days longer, and then replaced by strips of adhesive plaster, or tape dipped in collodium. The genital part of the dressing must be changed morning and evening, or more frequently if a desire for micturition be present. This ought to be done under spray of carbolic acid solution. The water is drawn. The vagina syringed with 2½ per cent. carbolized water. If the lochia should be fetid, or the temperature rise, the uterus is washed out with the same solution."

The Treatment of Abortion.—Three important papers bearing on this subject have recently appeared. The first of these is by Dr. T. J. Alloway, of Montreal, on "The Immediate use of the Uterine Scoop or Curette in the treatment of Abortions, *versus* Waiting, or the Expectant Plan." Dr. Alloway states that the reasons which have induced him to write this paper

are: The insufficient stress laid upon the importance of immediate removal of the secundines in abortion by the writers of even the most recent of obstetric text books, and his "wish to place before the profession the success which has attended the use of the dull currette, or uterine scoop in his hands in such cases." The author alludes to the mass of evidence to show the danger of hemorrhage and septicæmia in justification of the plea for immediate action when nature is incompetent.

He also alludes to "the occurrence of some discouraging experience I sustained during the first few years of practice" when he followed the teachings of the text books. Dr. Alloway advocates the use of the curette in preference to the finger, believing that the dull or blunt curette may be used to detach the placenta with less pain and greater safety to the patient than the finger, which, from its greater size, requires an amount of counteracting downward pressure or traction, which may be dangerous to the patient. In support of this he quotes from Savage as follows: "The uterus, when pulled down by a vulsellum until it seems to threaten some physical damage to the opposing structures, descends but about one and a half inches." Dr. Alloway reports a number of cases in support of his views.

Dr. Mundé's paper is entitled "The Immediate Removal of the Secundines after Abortion." The doctrines inculcated are in the main the same as those in Dr. Alloway's paper. He says: "I wish to add my testimony to that of Dr. Alloway, in favor of the forcible, (that is manual or instrumental) removal of the secundines immediately after the expulsion of the fœtus, in every case where the cervical canal is sufficiently patulous to permit the introduction of the finger or of the large dull curette or the placental forceps. Further if there is hemorrhage, or an offensive vaginal discharge, or if the temperature rises, or there is a chill, and the secundines are still retained, no matter how soon or how late after the expulsion of the fœtus, they should be at once removed, and, if necessary, the cervix dilated to facilitate the operation." As regards the methods of removal Dr. Mundé advocates the use of the finger, if the cervix is dilated sufficiently; anæsthesia being employed if necessary. In

cases where the cervix is somewhat dilated, but from tense or fat abdominal walls, the uterus cannot be forced down, then he uses a curette devised by himself. It is a modification or rather exaggeration of the Thomas' dull curette, and like it is flexible. This instrument and Mundé's placental forceps are figured in illustration of the paper. To dilate the cervix when this is necessary, Dr. Mundé prefers tupelo to anything else, claiming that it is easier, safer, and speedier than anything else, and states that by it he has in some cases been able to effect enough dilatation in an hour. After clearing out the uterus it is washed out with hot or ice cold carbolized water. In answer to questions frequently put concerning this method of treatment, the author asserts most positively that it is so free from danger that every physician can employ it, that the risk from forcible removal of the secundines is not greater than that from letting them alone. Dr. Mundé appends a table based on 57 cases occurring in his experience. Of these 8 had exhaustive hemorrhage and 5 septicæmia. Rapid recovery resulted in nearly all. In one only did death result. Septicæmia was the cause, and it was present before the operation. In another case there was mild cellulitis, with recovery. Drs. Alloway's and Munde's papers appear in the February (1883) number of the *American Journal of Obstetrics.*

The third paper referred to is that of Professor Spöndly of Zurich, and appears in the last number (Bd. IX, Hft 1, 1883) of the *Zeitschrist für Geburtshülfe und Gynäkologie.* It is entitled "Ueber das Active Einschreiten bei Abortus." (Active Interference in Abortion.) The paper is based on fifty-three cases of abortion treated by immediate removal of the placenta and membranes. The finger was used in all cases. Chloroform as anæsthetic when necessary, and after the operation washing out the uterus with carbolized water were employed. The results were entirely favourable to the method of treatment. A large proportion of the fifty-three cases were in multiparous women, and women advanced in years. A brief report of each of the fifty-three cases is embodied in the paper. There can be no doubt that the teachings

of the three authors just quoted indicate the tendency of the advanced men in the profession with reference to this important question. While it is quite true that many cases of abortion untreated or treated by the expectant method get well, it is equally true that many deaths from hemorrhage or septicæmia, and many cases of chronic invalidism from uterine disease, result from a policy of inaction. The inference ought to be obvious.

Solid Ovarian Tumours.—Mr. Knowsley Thornton, of the Samaritan Hospital for Women, London, has recently been giving his ovariotomy experiences. In April last he had done 338 ovariotomies; of these 10 were solid tumours. These cases were thus not numerous, but they had characters in common. In all menstruation was irregular—entirely suppressed; very irregular; now scanty and again very profuse; very painful, etc. On the other hand in ovarian cysts, as a rule, the menses are regular. The patients do not emaciate more rapidly, nor does Mr. Thornton think they suffer any more pain than the subjects of ovarian cysts. The diagnosis to be made is from uterine fibroids, and then irregular menstruation may mislead, but the facies is different. In fibroids of the uterus the face is often fat, even if blanched; in solid ovarian tumous on the other hand there is usually extreme wasting of face, neck, breast and arms. His experience is that there is much greater danger from the operation than from ordinary ovariotomy. Three of his ten cases died from the operation; of the subsequent condition and results the report is very interesting and important. Of the seven, three were very ill and recovered with great difficulty; four recovered easily; of the three, one only remains in good health, and had a child two years after the operation, but is now suffering from recurrence in the abdomen. The third is suffering from pelvic recurrence. Of the four who made good recoveries, one died within the year from peritoneal recurrence. The other three all died during the year from a diffuse sarcoma in various external and internal situations, and in the glands. This rapid and general diffusion of sarcoma after operations for its removal from the ovary makes Mr.

Thornton think it very doubtful if it be proper to operate at all for their removal; seeing that though life may be prolonged a little, the period of actual health is very short. At the time of writing the article, only two of the ten cases were alive, one only in perfect health; the other suffering from recurrence after, however, eighteen months of good health since the operation, of better health than she had enjoyed for years. The case of the patient who has borne a child was at the time of operation one of the most unpromising. The tumour being of such a nature as to make recurrence exceedingly probable. In view of all the facts of his experience, and that the patients are doomed to death more or less speedy if not operated upon, Mr. Thornton is still inclined to give the patient the chance of operation, unless there is distinct evidence of spread of the disease to the broad ligament or neighboring parts.—*Medical Times and Gazette.*

The Iodoform Treatment of Puerperal Lacerations of Perineum and Vagina, by Dr. C. Behm, Assistant at the University Obstetrico-Gynæcological Clinic of the Charté Hospital, Berlin. This is the title of a paper in the last number (Bd. IX, Hft. 1, *Zeitschrift f. Geb. und Gyn.*, 1883). The iodoform treatment of wounds and raw surfaces has been most extensively under trial in Germany for the last year or two. The author believes that there is no part of the body so well suited to the iodoform-dressing as the perineal region, which, on account of the constant necessity for passing of urine and feces, cannot be treated by Listerian or any dressing which covers the parts from contact with air for a few days. Iodoform has the quality so valuable in a dressing for wounds of this region, of adhering and even incorporating itself (verfiltzen) with the tissues of the part, so that when applied to a fresh raw surface it adheres for several days in spite of constant bathing and washing, or even syringing of the parts. It may be applied without any complicated method or apparatus to any part of the body. Salicylic acid powder recommended for the same purpose by Schmidt and Küster is not at all so well adapted. It does not adhere so well to the wound surface, is easily washed away, and

it is irritant, preventing union and causing burning pain. Von Langenbeck and Kuster have advised against the application of iodoform to wound surfaces in which we desire primary union, fearing that it may constitute a foreign body and so interefere with union. Behm, however, thinks that if we refrain from its use in this way we shall be deprived of an agent possessing a most valuable quality, that of limiting the quantity of wound secretions; and that when a small quantity is applied as an impalpable powder dusted over the wound, or, as Unna recommends in the form of iodoform-ether spray, it has, in his experience, caused no irritation, but, on the contrary, by lessening discharge, has assured the union by primary intention. In order to secure as complete asepticism as possible, the author proceeds as follows: The wound, operator's hands, and sutures are disinfected with carbolic acid five per cent. solution, or corrosive sublimate 1 to 1000. The latter, while a more energetic parasiticide than carbolic acid, has the disadvantage that it corrodes instruments and so renders it difficult to pass the needles. The wound surface had better be glazed. All bleeding is to be arrested. Ligatures being used if necessary. For moderate oozing, pressure with dry wadding is useful. Iodoform ether spray has a styptic effect. The dryer the surface the better does the iodoform adhere. It is applied as an impalpable powder sprinkled from a spatula, or dusted from a dredging box, or in the form of the iodoform ether spray. The sutures are then put in. After this is done, more iodoform is applied as powder or spray, and after drying of the surface iodoform collodion is pencilled over the surface. This usually separates about the 3rd or 4th day. The surface may be again sprinkled with iodoform, or dressed with carbolized or borated vaseline. Dr. Behm reports twenty-eight cases of incomplete and two of complete rupture extending through the sphincter and up the rectum. Of the twenty-eight incomplete cases, twenty-three united by primary intention. The two complete cases also united by primary intention, although in one case the sutures were not put in till thirty-six hours after labor, the surface having been soiled with both urine and fœces.

Beiträge zur Lehre der Castration der Frauen, von Wilhelm

Tauffer, Prof. in Buda-Pesth. (Contributions to the Subject of the Castration of Women. (*Zeitschrift f. Geb. und Gyn.*, Bd. IX, Hft. 1, 1883.) The author reports twelve cases of the operation for small ovarian tumours; cystic follicular degeneration of the ovaries; diseases of the uterus which render menstruation difficult or impossible, the ovaries performing their function in a normal manner; myo-fibromata; displacements of the uterus and ovaries; periuterine and periovarian inflammation; pelvic cellulitis and salpingitis; insanity connected with the sexual function. All the cases recovered. The following are the author's conclusion from his experience:

1. Castration with proper precautions is not a very dangerous operation. The mortality is under ten per cent.

2. The operation should be done under antiseptic precautions and carbolic spray. The abdomen is to be closed, and drainage is only occasionally necessary.

3. Objection to the operation on the ground that the patient is near to the climacteric, is only conditionally valid, inasmuch as this change occurs at varying ages and cannot be definitely predicted.

4. Both ovaries ought, as a rule, to be removed, even when one only seems to be diseased. This conclusion is justified by the fact that the remaining ovary is predisposed to the same disease.

5. The removal of the fallopian tubes ought to be effected at the same time.

6. Hystero epilepsy is curable by castration.

7. The group of symptoms designated by the term hysteria, may often be traced to disease of the ovaries.

8. The question of what influence may be expected on the nutrition of uterine fibro-myoma, by the ligature of certain large nutrient arteries without castration, is well worthy of consideration and experiment.

9. In forming a prognosis, it is important to remember that immediate menopause results only in those cases in which adjacent organs show no sign of disease. Any inflammatory condition delays the menopause.

10. The ultimate result of castration cannot be determined with certainty till several months after the operation.

11. The question as to how far the development of psychoses is influenced by diseases of the female sexual organs is worthy of consideration.

12. And so also whether such psychoses are curable by castration.

Lacerations du Col Uterin, par le Dr. Agathonoff.—This is the title of a paper read before the Academy of Medicine of St. Petersburg, and published in the August (1883) number of the *Annales de Gynecologie.* The paper is based on 14 Emmet's operations, of which 13 were performed by Professor Slaviansky and 1 by the author. The first trachelorrhraphy in Russia was done by Slaviansky in 1880. In the majority of the cases the operation was done without the preparatory treatment advised by Emmet, and yet the results were, in the large majority of cases, entirely satisfactory. No anæsthetic was employed. The lithotomy position was that in which the patients were placed for operation. Irrigation of the field of operation with 1 to 100 carbolized water was used. The sutures were introduced before denudation of the lacerated surfaces, the object being to check instantly any unexpected bleeding. Emmet's needles and needle holder were not used, but, instead, a tubular needle used for perineorrhaphy and fistula operations. The denudation was effected partly by a double-edged lancet-shaped bistoury and partly with scissors, the limits of the intended denudation being first marked off on the edges. The author believes the following conclusions justified by Professor Slaviansky's and his own experience :—

1. The cure of the symptoms produced by lacerations of the cervix is obtained principally by union of the edges.

2. Long preparatory treatment is only necessary when there is intense metritis and cystic degeneration of the endometrium. Apart from other reasons, in such cases, without this preparatory treatment, union of the denuded edges cannot with certainty be obtained.

3. Finally, it must be admitted that Emmet's operation is the

only suitable remedy for laceration of the cervix. No other remedy as successful can be substituted.

It will be admitted by nearly all observers who have experience of the operation that the conclusions here formulated are just.

A Note on Uterine Myoma: its Treatment and Pathology.—This is the title of a paper read by Mr. Lawson Tait at the last meeting (July 4, 1883) of the Obstetrical Society of London. The author took occasion to reiterate his now rather well-known views with reference to menstruation and ovulation. He thought they were independent functions, having, perhaps, a community of purpose. Removal of the ovaries often did not arrest menstruation, but removal of the fallopian tubes nearly always did so. But in one case in which he removed ovaries, tubes, and part of the fundus uteri, menstruation continued more than a year. He thought the term "myoma" should entirely supersede the incorrect term "uterine fibroid." The growth of these tumors is limited to the period of sexual activity, it is influenced by the menstrual functions, and he thought probably its ultimate cause would be found in some disturbance of the nervous body which governed that function. The presence of a myoma indefinitely delays the menopause. He deprecates the triple classification of myomas into submucous, intramural and subperitoneal. For pathological and surgical purposes, he proposed a new subdivision into the nodular and concentric. The latter consists of a uniform hypertrophy of the muscular tissue of the uterus, in the midst of which the canal lies centrally; the tissue of this form is loose and often very œdematous. Of the nodular myoma he proposed two varieties—the simple and multinodular. He believed that each nodule was seated on a central arterial twig; that its growth was endogenous, the older tissue being on the outside. The dependence of such growth on menstruation was proved by the fact that arrest of menstruation stopped the growth, or even caused the complete disappearance of such tumors. This in several cases had been brought about by the removal of the tubes only. He had treated 54 cases of uterine myoma by removal of the uterine appendages, with 3 deaths, a mortality of

5.5 per cent—a mortality in striking contrast to the results of hysterectomy. Of the 51 who survived, in 38 the results had been carefully followed, and were everything that could be desired. In three, the tumors were or became malignant. In three others they continued to grow, although menstruation had been arrested.

During the discussion which followed, Dr. Herman stated that he had published a case in which the symptoms of fibroid polypus first appeared 16 years after menopause. The history of patients after operations like those of Mr. Tait was of great importance, for patients not benefited often did not return to the operator, and he, therefore, was apt to get a too favorable impression of the results.—(*Lancet.*)

Correspondence.

DIGITALIN, NOT DIGITALISIN.

To the Editor of THE CANADA MEDICAL & SURGICAL JOURNAL.

DEAR EDITOR,—In your last issue, you report a member of the Medico-Chirurgical Society as saying that he had adminis tered digitalin in ¼ grain doses hypodermically, without very much effect. At the meeting I expressed doubt of the genuineness of the drug. I have now reason to believe that the article used was a nostrum, put on the market by a manufacturing firm under the name of Digitalisin, and not the Pharmacopœia article. In my humble opinion, the profession should not encourage the production of articles having names similar, or nearly similar, to those in the Pharmacopœia, as leading to dangerous confusion.

When Digitalin, Morphine, Atropine, &c., are prescribed, only the articles recognized as such in the Phar. Br. would be dispensed by a competent pharmacist.

The compilers of the Pharmacopœia give the dose of digitalin as $\frac{1}{60}$ to $\frac{1}{30}$ grain by the mouth.

T. D. R.

MONTREAL, Aug. 4, 1883.

Reviews and Notices of Books.

Manual of Gynecology.—By D. BERRY HART, M.D., F.R.C.P.E., and A. H. BARBOUR, M.A., B.Sc., M.B. New York: William Wood & Co.

This work, in two volumes, is reproduced from the original Edinburgh edition as the January and February numbers of the Library. The authors are a former (Hart) and the present (Barbour) assistant to the Professor of Midwifery and Diseases of Women in the University of Edinburgh.

Dr. Hart is well known from his most valuable studies of the anatomy of the female pelvic floor. These researches are of course embodied in the work before us, and constitute perhaps its most valuable part. It is certainly this part which characterizes the book when comparing it with other materials. Too much reliance has perhaps been placed on frozen sections to indicate the relations of the various parts. As in an article on the "Topographical Anatomy of the Female Sexual Organs," in the *American Journal of Obstetrics*, the freezing process frequently alters the relations and relative proportions of parts. The other parts of the work are admirable. It is a marvel to find how much has been compressed into the book. In their anxiety to do this, the authors have sometimes sacrificed literary style to the necessity for being brief. The *Lancet* reviewer in speaking of the author's article on "Vaginal Specula," says: "It might be not unreasonably inferred from the chapter on this subject that their chief use was to discover or conceal lacerations of the cervix." This is just the kind of criticism we should have expected from the typical conservative English gynecologist; we are glad to know that even he will soon be a curiosity. Led by Playfair in London, and Simpson, Angus McDonald, and our authors in Edinburgh, the importance of laceration of the cervix, and Emmet's operation for its cure, are being recognized. As might have been expected, from other standpoints, the methods of the Edinburgh school have undue prominence in the book. As an instance of this, the volsella are almost everywhere recommended in preference to

Sims' tenaculum. Now, while there are instances where the volsella cannot be dispensed with, we contend that whenever the tenaculum with its single fine puncture will answer our purpose, it ought to be preferred to the other instrument with its four (to some extent) irritative punctures. We heartily recommend this book to our readers. It is one of the text books recommended to the class in gynecology of McGill University.

The Diseases of Women: A Manual for Physicians and Students.—By HEINRICH FRITSCH, M.D., Professor of Gynæcology and Obstetrics at the University of Halle. Translated by ISIDOR FURST. With 150 wood engravings. New York: William Wood & Co.

This volume is the March number of Wood's Library. The author is well known to readers of the gynæcological literature of Germany as the editor-in-chief of the weekly *Centralblatt für Gynakologie*, and the author of Section III, "On Displacements of the Uterus," of Billroth's celebrated handbook on Diseases of Women. We have examined this book somewhat carefully, and are assured that this translation will be a valuable addition to the library of men who are not familiar with the original language, and who desire to become familiar with German methods. We always feel inclined to test a new author on diseases of women by his appreciation of Sims' methods of examination. In this respect Germans, the author included, are fairly up to the mark.

The translator is not very familiar with English idioms, as appears in many parts of the work.

Manuel des Injections Sous-Cutanees. — Par M. BOURNEVILLE, Medecin de Bicêtre, et Bricon docteur en medecine. Paris: Delahaze & Lecrosnier.

This little handbook is one which may prove very useful to many practitioners. The hypodermic method is one now so universally followed that it is very necessary to be acquainted with the best mode of using each of a great many drugs. The facts concerning these are often not found in the ordinary text-books,

but exist only in the pages of periodical literature. To collect and present these in an easily accessible form has been the aim of these writers. Each drug has a short description of its physiological effects, especially those following its hypodermic employment, together with the formulæ for those solutions which have been found from experience to be the most suitable. In any doubtful case, the name of the authority is almost always given. The whole is prefaced by a brief account of the history of the method, the seats of selection, mode of preparing the solutions, the various forms of instrument which have come into general use, and the local accidents which are liable to occur.

Illustrated Medicine and Surgery.—Edited by GEORGE HENRY FOX and FREDERIC R. STURGIS. Vol. II., No. 2. New York: E. B. Treat.

This number contains a beautiful lithograph of an enormous enchondroma of the humerus. An illustration of the physiognomy of a case of intellectual monomania, with mental depression, by Wm. A. Hammond. Colored plates of cases of tricophytosis barbæ, and of rupture of the choroid, and reports, with woodcuts of interesting examples of syphilitic stenosis of the larynx, multiple sarcoma of the skin, and severe deformity of the lower eyelid.

Therapeutic Handbook of the United States Pharmacopœia: Being a condensed statement of the Physiological and Toxic action, Medicinal value, Methods of Administration and Doses of the Drugs and Preparations in the Latest Edition of the United States Pharmacopœia, with some remarks on Unofficinal Preparations.—By ROBT. T. EDES, B.A., M.D., Professor of Materia Medica in Harvard University, President of the American Neurological Association, Visiting Physician at the Boston City Hospital, &c. New York: Wm. Wood & Co.

This is one of a number of very useful hand books that will necessarily crop up from time to time, as an adjunct to the new Pharmacopœia. The work, as admitted by the author in his

preface, is evidently written for the practitioner rather than the pharmacist or student. Each article of the Pharmacopœia is taken in its turn—the French, German and common names being given with concise, and in the case of some of the more important drugs, voluminous therapeutic notes with the doses; these latter, although not coming with the authority of the compilers, can be accepted as fair ordinary doses. After exhausting the pharmacopœial list, the author then gives some remarks upon a few non-officinal drugs, not admitted in the Pharmacopœia, but largely used in general practice, and these will be read with interest. The work ends with a classified index of drugs, and a very useful table of poisons and their antidotes; but we cannot see the necessity of giving Oleum Gossypium the first place as the antidote to Carbolic Acid over Oleum Olivæ—an oil more known and much more likely to be found upon the shelf of the housekeeper.

The Transactions of the American Medical Association.—Instituted 1847. Vol. XXXIII. Philadelphia, 1882.

The results of the St. Paul meeting, as embodied in this volume, afford the best possible warrant for the change in the mode of publication from an annual volume to a monthly journal, which has now taken place. The volume is a small one and contains, exclusive of the reports, addresses and minutes, but twenty-two papers, not one of special merit. The truth is that the various societies now in existence, devoted to special branches, have killed the sections of the American Association. Compare the Proceedings of the Surgical Association with that of the surgical section, and our meaning is clear. In the present volume there is not a single paper on anatomy or surgery. With the more speedy method of publication and the more extended circulation which the journal will have, we predict better contributions to and more active work in the sections of the association.

Books and Pamphlets Received.

A TREATISE ON THE DISEASES OF THE EYE. By J. Soelberg Wells, F.R.C.S. Fourth American from the third English edition, with copious additions. By Charles Stedman Bull, A.M., M.D. Illustrated. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Brothers

THE PRACTITIONER'S READY REFERENCE BOOK—A HANDY GUIDE IN OFFICE AND BEDSIDE PRACTICE. By Richard J. Dunglison, A.M., M.D. Third edition. Philadelphia: H. C. Lea's Son & Co. Montreal: Dawson Bros.

THE UNTOWARD EFFECTS OF DRUGS. By Dr. C. Lewin. Second edition. Translated by J. J. Mulheron, M.D. Detroit, Mich., Geo. S. Davis.

HANDBOOK OF ELECTRO-THERAPEUTICS. By Dr. Wilhelm Erb. Translated by L. Putzel, M.D. With 39 woodcuts. New York: Wm. Wood & Co.

THE MICROSCOPE AND ITS REVELATIONS. By Wm. B. Carpenter, F.R.S., &c. Sixth edition. Illustrated by 26 plates and 500 wood engravings. Vol. II. New York: Wm. Wood & Co.

A NEW SCHOOL PHYSIOLOGY. By Richard J. Dunglison, A.M., M.D. Illustrated. Porter & Coates, Philadelphia.

A HISTORY OF TUBERCULOSIS FROM THE TIME OF SYLVIUS TO THE PRESENT DAY: Being in part a translation, with additions from the German of Dr. Arnold Spina. By Eric Suttler, M.D. Cincinnati: Robert Clark & Co.

TREATMENT OF DISEASES OF INFANCY AND CHILDHOOD. With over four hundred Formulæ and Prescriptions. By Charles H. Goodwin, M.D. New York: C. H. Goodwin, M.D.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, May 25th, 1883.

R. A., KENNEDY, M.D., PRESIDENT, IN THE CHAIR.

The following resolution was passed :—

Resolved,—That this Society has heard with deep regret of the death of Dr. W. E. Scott, one of its oldest and most respected members,—a prominent member of the medical profession, a representative governor of the Province for many years, a well-known and successful teacher as well as an energetic surgeon and practitioner, and feels sure that his loss will be widely felt and much deplored.

Resolved,—That this Society extends its deepest sympathy to Mrs. Scott and her family in their affliction, and that a copy of these resolutions be sent to Mrs. Scott and to the press.

DR. OSLER exhibited an *Aneurism of the Anterior Cerebral Artery*. There was meningeal hæmorrhage about longitudinal fissure, and at the base. On separating the median surfaces of the hemispheres, and clearing the blood away, a small nodu-

lar projection was seen on the right side just about the middle of the convolution of the corpus callosum. On further dissection this proved to be a small aneurismal sac, on a branch of the anterior cerbral. It was imbedded in the sulcus between the gyrus fornicatus and precuneus, and the substance about it was lacerated. The rupture was at the edge of the sac, and of considerable size. In the white matter, half an inch beyond the aneurism, there was a round, well-defined spot of hæmorrhage, the size of a cherry. Dr. Bell said the above was removed from a boy six years of age, who had been brought to hospital in an unconscious condition; with feeble pulse, pale face, eyes and head turned to right and left hemiplegia,—he remained so till death, six hours later; no wound was found. Some time before he had been run over by a baker's cart, which left him halt in his left leg. Three weeks before his last accident he had fallen from a hay loft. Nothing followed this but drowsiness for a short time.

Uterine Fibroid Polypus.—Dr. Gardner showed this specimen which he had removed from the posterior surface of the uterine wall close to the inner os. Very slight hæmorrhage followed, which was easily stopped by tr. iodine. Dr. G. T. Ross, whose patient the woman was, gave the following particulars: Mrs. L. had been married ten years, no children; had good health till two years ago, when she began to suffer from dysmenorrhœa. Had also more or less pain throughout pelvis, and radiating down right thigh. About six months ago menorrhagia set in, and more recently the flow became continuous, alternating occasionally with a watery discharge from uterus. She became markedly anæmic, and complained of uterine tenesmus. An examination revealed the above tumour projecting from the os.

Dr. Roddick exhibited a photograph and cast of a case of extremely varicosed condition of the veins of the leg operated on successfully by Dr. Malloch of Hamilton, by excising portions of the affected veins, and by carbolic injection.

Dr. Kennedy shewed photographs of Barnum's alligator-skinned child, at the birth of which Dr. Kennedy attended the mother. He said it was an ordinary labor, but the baby's skin was

as if varnished, but presented no cracks or creases, and the child could not open its eyes; he ordered it to be rubbed with Cod Liver Oil. Dr. Kennedy lost sight of his patient, as the parents soon after left the city. Dr. Fox, of New York, seeing such a beautiful specimen of Ichthyosis at Barnum's Show, wrote to Dr. Kennedy for information about the history of the case.

Lawson Tait's Operation.—DR. GARDNER exhibited a set of uterine appendages (ovaries and Fallopian tubes) which he had removed a week previously. The ovaries were somewhat enlarged, and contained several cysts, one of them being three-quarters of an inch in diameter. The Fallopian tubes were slightly distended with a catarrhal secretion.

The patient was a charwoman, æt. 36, unmarried, never pregnant. Began to menstruate at 17; flow always copious, with clots, and attended with hypogastric pain. Otherwise she had fair health till a few years ago, when, after reaching over-head to wash a ceiling, she suffered increase of pelvic and lumbar pain, with "painful sitting" and aggravation of the dysmenorrhœa and menorrhagia. When patient first came for advice, menses had continued for a month. Examination revealed a small, circular os uteri, with a bulky, completely retroverted uterus, measuring 3½ inches. The channel was tortuous. Marked tenderness around uterus, with thickening felt in posterior cul de sac. After dilatation with a small laminaria tent, a fibro-cellular polypus of the size of a cherry was discovered hanging through the internal os, attached by a pedicle further up. This was removed, and the curette then passed over the whole endometrium, bringing away a quantity of soft granulation-like tissue. Immediately afterwards the endometrium was swabbed over with Churchill's tinct. of iodine. The uterus was then replaced, and an Albert Smith pessary introduced. Hot vaginal douches were prescribed, and rest in bed enjoined. No relief followed. The next two periods were profuse, with clots and pieces of membrane, found by microscopical examination to be the uterine lining membrane. She was then treated for some weeks by careful tamponing of the vagina with cotton soaked in glycerine, with iodoform. This gave temporary relief, but menstruation

continued to be excessively painful, and attended with vomiting and great general prostration. Oophorectomy was proposed as a *dernier ressort.* The patient eagerly grasped at the idea of any expedient that gave a prospect of relief; so, on the 18th of May, nine days after the cessation of menstruation, the operation was done. No difficulties were encountered. The ovaries and tubes were not adherent. They were easily raised between the edges of the abdominal wound, ligatured, and cut away. A good deal of abdominal pain and incessant vomiting were suffered for a few days. Temperature in the vagina never rose over 102°F. The patient was kept profoundly under the influence of opium (Battley's sed. solution) given hypodermically, and nourished exclusively per rectum for a week. Only small pieces of ice given by the mouth. The menses, or a metrostaxis of blood of dark cherry-red colour, appeared on the second day, lasting four or five days. The abdominal incision united perfectly. After the first week, recovery, though slow, was steady. The patient, who had been a terrible sufferer from indigestion, was much improved in this respect, as in many others. Defecation, which formerly was agonizing, now almost painless. Chloasma (uterine), formerly most marked, now disappearing fast. All the symptoms much mitigated.

June 17th.—A month since operation. Improvement in all symptoms. It is slow as regards pelvic pain. This symptom, depending as it does on pelvic peritonitis, metritis and endometritis, cannot disappear entirely for some time to come.

Dr. Trenholme said he was the first to perform this operation in Canada. His patient is now enjoying good health, and has not menstruated since. He believed the operation ought to be done oftener than it is.

Dr. Roddick asked if it were not possible to make the operation less serious, by merely ligating the Fallopian tubes between the uterus and ovaries and then cutting them through, which operation could be done with a very small opening in abdomen.

Dr. Gardner said no, for it might produce gangrene or septic peritonitis, and often the ovaries are in a bed of inflammatory exudation.

DR. TRENHOLME said the operation might be performed through the vagina if there were no adhesions.

DR. OSLER was surprised to find that ovaries so slightly diseased required such heroic treatment.

DR. GARDNER said the operation was indicated even if the ovaries were healthy, for you remove the organs which are the cause of all the monthly symptoms. His case was not ovarian, but uterine dysmenorrhœa.

DR. F. J. SHEPHERD read the following paper on *Two Cases of Wound of the Palmar Arch:* Perhaps there are no more troublesome cases to treat or ones that give rise to greater anxiety than wounds of the palmar arch. If treated properly, as a rule, these cases terminate favourably, but even with the most skillful treatment, serious results sometimes follow. It seems extraordinary how often wounds of the palmar arch are badly treated, when every text book in general and minor surgery gives such definite directions as to what should be done. But a case is brought to the surgeon where there is a small wound in the ball of the thumb which has bled freely at first, but now the hæmorrhage is arrested, and he probably merely applies dressing, with perhaps a small compress, and sends the patient away; in a day or two when the clot breaks down, profuse hæmorrhage comes on, (possibly at night) and before a surgeon can be found, the patient has lost a great deal of blood. Now a compress may not arrest the bleeding, and the brachial artery may have to be tied to save life, or the forearm may in worst cases have to be amputated. These serious results would not have happened had the surgeon in the first instance enlarged and thoroughly cleansed the wound, plugged it from the bottom with lint, placed a compress in the palm of the hand, and bandaged the whole firmly and evenly, and then left alone for three or four days. Very often the wound is plugged, and a compress and bandage applied; but the anxiety or over-officiousness of the surgeon prompts him to examine the wound daily, to see that everything is all right. This disturbs the parts and oozing commences, which cannot be arrested by the most careful pressure, and in consequence the serious operation

of tying the brachial has to be resorted to. The truth of the old axiom that "meddlesome surgery is bad surgery," cannot be too often insisted on. When the wound is once plugged and properly bandaged, it should be left undisturbed for at least three or four days, if the pain or discomfort is great, morphia should be administered to allay it; but on no account should the wound be disturbed. In exceptional instances the plug causes a grangrenous condition of the wound, or a diffuse cellulitis is developed and the surgeon may have to resort to amputation to save life. I shall now relate two cases which came under my observation during the past year, and which fortunately terminated favorably, though at the time they caused me much anxiety.

Case I.—J. S., aged 15, while washing bottles fell with one in his hand. The bottle broke, and cut him severely in the ball of the left thumb, a little to the ulnar side and parallel to the first metacarpal bone. There was considerable hemorrhage at the time which was controlled by a tight bandage round the arm. In this condition he was brought to one of the hospitals; as there was no hemorrhage from the wound, it was not explored but a couple of stitches were put in and the wound was dressed with dry absorbent cotton, kept in position by a light bandage. The boy was then sent home. This happened on Tuesday, March 7th, 1882. The dry dressing was left on till Saturday the 11th, when, as the wound was suppurating, it was removed and replaced by water dressing. On Saturday night profuse hemorrhage suddenly set in from the wound. The boy was brought to the General Hospital as quickly as possible, and one of the house staff controlled the hemorrhage (temporarily) by means of a cork compress and tight bandage. On Sunday evening there was slight oozing, but very little blood was lost till next morning, Thursday 13th, when the hæmorrhage became again profuse. I saw him now for the first time. The bleeding was controlled by an Esmarch bandage, and the wound was examined. It was found to extend through the ball of the thumb down to the bases of the metacarpal bones of the thumb and forefinger, which could be felt quite bare. On cleansing

the wound and loosening the Esmarch, no bleeding point could be discovered, as the tissues were much infiltrated with effused blood, which also welled up from the bottom of the wound. The Esmarch having been again applied the wound was thoroughly cleansed and plugged from the bottom with a firm cone of absorbent cotton, soaked in carbolic oil (1-16), over which was placed some lint folded square and dry absorbent cotton. The whole was kept in position by a short flat stick, placed across the palm and held firm by a figure eight bandage going round the two ends of the stick, and over the back of the hand. By this means good counter pressure was effected. The hand was now closed on the palmar pad and stick and bandaged firmly; the bandage was continued to near the elbow (which was flexed) and then carried round the forearm and arm, so that the elbow was fixed in a position of extreme flexion. The boy was sent home to bed and a quarter of a grain of morphia was prescribed. The hand was left in this position for four days, during which time the boy's temperature kept at about 100½° F. There was considerable pain of a throbbing character, but a quarter of a grain of morphia at night always procured sleep. The bowels were kept open with calomel; at the end of the fourth day, an Esmarch having been applied to the forearm, the wound was examined, and the plug of cotton wool removed. It came away quite easily and was bathed in a healthy pus; the bottom of the wound was granulating freely. The skin in the neighborhood was perfectly healthy, with the exception of a small spot on the inner edge, from which a slough came away in a day or two. As there was much pus between the first and second metacarpal bones, and the only tissue at that point between bottom of the wound and the back of the hand was a thin skin, an incision was made through it, and a short drainage tube introduced. On loosening the Esmarch no hæmorrhage took place. The large hole into which the wound was now converted was filled with absorbent cotton soaked in carbolic oil, and the hand was placed between two splints, well padded with absorbent cotton (dry), and carefully and firmly bandaged, and slung across the chest.

That night the boy slept well without an opiate, and the case thenceforward progressed most favorably, the large cavity taking, of course, some time to fill up, which it did from the sides principally. After the first dressing, cotton wool saturated with iodoform was substituted for the carbolic oil dressing, and had the remarkable effect of almost preventing suppuration. By April 7th the wound was completely healed. When last seen the boy had only a little stiffness of the thumb. The cicatix was not very noticeable.

CASE II.—E. C., butcher, aged 58, whilst sawing a meat-bone, accidentally cut his left thumb with the saw, on the back of joint, between 1st and 2nd phalanges. He paid little attention to the wound, and merely kept it tied up with a piece of rag, but after seven or eight days the wound began to inflame, and poultices were applied. I saw him for the first time two weeks after the receipt of the injury (Sept. 12th, '82). At that time the whole hand was œdematous, the thumb greatly enlarged, boggy to the feel, and covered with an erysipelatus blush. The wound was discharging a stinking pus. Temperature 102°F.; pulse 104. On examining him further, it was found that the pus had burrowed up in the inner side of the thumb as far as the middle of the metacarpal bone. Two deep incisions were made, the one in the inner side of the first phalanx and the other on the back of the metacarpal bone, and a large quantity of pus was evacuated. The cavity was washed out with a 1 to 20 solution of boroglyceride, and a drainage tube was put through the two incisions from the upper to the lower, and the thumb was dressed with lint soaked in boroglyceride; a well padded splint was placed on the palmar surface of the hand, and the whole evenly and firmly bandaged with a gauze bandage. On re-dressing the hand two days after this (Sept. 14) and withdrawing the tube, a free bleeding took place, the bleeding point not being found on enlarging the wound. It was plugged with cotton soaked in boroglyceride and glycerine equal parts; over this a pad of boracic lint was placed, and the whole firmly bandaged to a pasteboard splint. By this means the hemorrhage was completely controlled. On removing the dressing three days after,

the plug came away easily, and was bathed in healthy, sweet pus. No hemorrhage occurred. The hand looked much better, was reduced in size, and no erysipelatous blush was present. Temperature and pulse normal. Wound dressed as before with boroglyceride solution. The dressing was changed every third day, and all went well for more than a week, when suddenly an alarming hemorrhage occurred whilst he was straining at stool. The loss of blood was so great that he fainted. The friends partially arrested the hemorrhage by tying a silk handkerchief around the wrist. I was immediately sent for, and on arriving at the house I put on an Esmarch bandage and examined the wound. I again enlarged it, and cleaned it of clots, but on loosening the bandage, could not detect the bleeding point. The blood seemed to well up from the bottom of the wound, which extended the whole length of first phalanx. I reapplied the Esmarch, cleaned the wound of clots, and plugged it firmly from the bottom with lint soaked in equal parts of boroglyceride and glycerine, and bound the hand and thumb firmly on a splint, well packed with boracic cotton. I also put a compress over the radial artery, near the wrist, and kept the hand against opposite shoulder. The dressings were left on for four days, at the end of which time the patient had a severe rigor, followed by a temperature of 104°F. I then removed the dressings and let out about an ounce of perfectly sweet pus. The wound was redressed with boroglyceride, and covered with a pad of boracic cotton, the splint reapplied, and the whole kept in place by a firmly and evenly applied gauze bandage. No hemorrhage occurred after removal of the Esmarch, which was applied during the dressing; and from this time forward the case progressed favorably, the wound granulating from the bottom.

No doubt, in this case, the drainage tube ulcerated through either the princeps pollicis artery or a branch from the radial, which so often passes over the web of the thumb to complete the superficial arch, and which is also connected with the deep arch by a short trunk. Fortunately, by the thorough drainage the cellulitis had been controlled before the severe hemorrhage

came on. The second hemorrhage was due no doubt to the displacement of the clot by the straining at stool.

Testis in perinæo.—DR. R. L. MACDONNELL related the case. The patient is 15 years old. The left testicle has rested in the perinæum from the time of his birth. It is situated slightly to the left of the ano-scrotal raphe, rather nearer the anus than the scrotum. The organ is well developed, and freely moveable. It can be put into its proper place, but cannot be retained there. The scrotum is not so well developed on the left side as upon the right. There is left inguinal congenital hernia. The boy has been under observation for the last five years. He is said to have been born prematurely at the sixth month, and up to the present time has been very delicate, but the deformity has, as yet, caused him no inconvenience.

Nitro-Glycerine in Epilepsy.—DR. F. W. CAMPBELL spoke of the good effects of a one per cent. solution of nitro-glycerine in two cases of epilepsy. The first was a young woman who used to have an attack every four or five weeks; occasionally would be free for about two months. Gave her one drop three times a day, since which time (Dec. 16) has not had a single attack. The second case was a man whose attacks varied in frequency from three or four a day to one in two or three weeks. Three months ago put him on one drop doses three times a day. He has not had an attack since.

DR. HENRY HOWARD asked if these were cases of pure epilepsy, because the nitro-glycerine treatment has not proved to be of much use in true epilepsy—that is, where there is loss of memory and micturition during the seizure.

DR. CAMPBELL did not know if his patients micturated, but believed they were true epileptics.

DR. HENRY HOWARD said that according to modern alienists, loss of memory and micturition must be present else it is not true epilepsy, and the treatment of most use in these cases is tying the internal carotid. This is useless in the pseudo cases.

DR. KENNEDY mentioned having had good success in one case of epilepsy with 10-grain doses of borax three times a day.

NEW BRUNSWICK MEDICAL SOCIETY.

The third annual meeting of the above Medical Society was held in the Oddfellows Hall, St. John, on the 17th of July, 1883. The President, Dr. S. Z. Earle, called the meeting to order at 10 a.m. Those present enregistered their names and paid their dues. The following were present: Drs. S. Z. Earle, D. E. Berryman, D. M. Jonah, Jas. Christie, L. C. Allison, F. N. Welling, Chas. H. L. Johnston, Thos. Walker, Frank A. Nevers, W. A. Fairweather, R. Percy Crookshank, H. Geo. Addy, J. T. Steeves, J. W. Daniel, Geo. P. Caldwell, H. P. Reynolds, B. McMonagle, J. G. Atkinson, P. R. Inches, J. G. Nugent, J. N. Smith, J. H. Wilson, Joseph Andrews, John Berryman, Thos. W. Musgrove, W. J. Norfolk, S. G. Woodforde, B. Travers, P. R. Moore, F. MacFarlane, W. F. Coleman, G. A. Hetherington, James H. Gray, W. M. Caldwell, Geo. A. Hamilton, J. Z. Currie, Henry C. Preston, James Hutchison, E. M. Patterson, G. E. Coulthard, T. C. Brown, B. N. McCleery, Geo. McKay, J. E. March, J. D. White, M. C. McDonald, G. M. Duncan, J. C. Mott, Wm. Bayard, Lau. McLaren, E. A. Vail, G. R. J. Crawford, G. B. Noyes, A. B. Atherton, J. J. Lawson, J. E. Church, Jno. J. Gaynor, M. Sheffield, Geo. E. Hetherington, M. H. Macdonald.

The minutes of last annual meeting were read and confirmed.

Dr. Allison, from the By-Law Committee, read the report, which was adopted after a few trifling amendments.

Dr. Inches, Treasurer, submitthd his report. Income, $40; expenditure, $34.70; leaving a balance on hand of $5.30.

Dr. Coleman read the report of the committee to arrange the business of the meeting.

Dr. Coleman moved that the President appoint a committee to arrange a scale of fees for the N. B. Med. Society. Seconded and carried. Drs. Coleman, Brown, Wilson, Jas. Christie and Moore were appointed that committee.

Dr. Coleman moved that a committee be appointed by the President to consider what means may be taken by the Society to assist the Council to induce physicians to register and to pre-

vent unqualified persons from practising. Seconded by Dr. Travers. Carried. Drs. Coleman, Allison, McFarlane, Duncan, D. E. Berryman, G. P. Caldwell and Daniel were appointed that committee.

DR. WALKER, from the committee in the case of Dr. McKay, asked an extension of time to prepare their report. After a discussion, in which Drs. D. E. Berryman, Patterson and Travers took part, the request was granted.

DR. PATTERSON then read the report of the committee appointed to revise and amend the N. B. Medical Act, 1881.

The report was, on motion of Dr. Inches, received and laid on the table.

The PRESIDENT (Dr. Earle) then delivered the annual address, taking for his subject "General Principles of Diet."

The election of officers was then proceeded with by ballot, and the following members were declared elected:—President, Dr. Vail; 1st Vice-President, Dr. Walker; 2nd Vice-President, Dr. Patterson; Secretary, Dr. G. M. Duncan of Bathurst; Corresponding Secretary, Dr. Coleman, St. John; Treasurer, Dr. Nevers; Trustees, Drs. Daniel, Allison and Berryman.

DR. BAYARD, President of the Council of Physicians and Surgeons of New Brunswick, then read a report, which was, on motion of Dr. Daniel, seconded by Dr. Patterson, received and ordered to be entered on the minutes.

DR. CURRIE read a "Report of Cases in Practice"; 1st. A case of Lupus exedens of about nine years standing, associated with Lupus erythematodes; 2nd. Nævus of the face treated by electrolysis. (This paper will appear in the next number of this Journal.)

At 8 p.m. a conversazione was held. An excellent display of instruments was made by Drs. John and D. E. Berryman and Dr. Coleman, and others. Refreshments were served by a committee of St. John ladies and a pleasant time spent. A vote of thanks to the ladies called forth pithy and witty remarks from Drs. Walker and Moore. Meeting adjourned to meet at 9.30 a.m. of following day.

SECOND DAY—JULY 18TH.

The President (Dr. Earle) in the chair.

DR. J. G. ATKINSON, Oakhill, read a paper on "Sponge and Sea-tangle Tents in Gynecological Practice." The materials, forms, methods of preparing, qualities, and modes of introducing were fully described; length of time tent should be retained, mode of removal and effects and dangers were lucidly explained, as also their use as means of diagnosis and treatment. Cases were given in illustration of these statements.

DR. PRESTON moved order of business be suspended, and the Amendments to the Medical Act proposed by Committee taken up, seconded by Dr. D. E. Berryman.

DR. ATHERTON moved in amendment that order of business be continued, seconded by Dr. Inches and carried.

DR. PATTERSON moved that five minutes be allowed each member for discussion, seconded by Dr. Brown. Carried.

DR. MUSGROVE highly appreciated Dr. Atkinson's paper.

DR. PATTERSON said it was officiousness to use tents in many uterine diseases, *e.g.*, sub-involution, potash salts with ergot were sufficient. It was highly objectionable to give woman an idea she had uterine disease.

DR. BROWN related a case of "Fishbone in Rectum." Twelve years before patient had, while laughing, swallowed a mouthful of chowder without mastication. For a month there was pain in the stomach; removed then entirely after a glass of brandy; no further trouble till day of removal, when there was the most excruciating pain calling for examination, which resulted in its discovery and removal.

DR. GAYNOR, Debec, read a paper on "Chloroform as an Anæsthetic—its physiological action and therapeutic value."

DR. PATTERSON declared this another valuable paper and agreed with Dr. Jonah that they should be published with the transactions of the society.

DR. COLEMAN said that in his experience death came from the heart, and he failed to understand why it was recommended to study the breathing and pay no attention to the pulse. Ether is safer because a cardiac stimulant.

DR. MUSGROVE, in regard to stimulants administered before using chloroform, said it added to the danger and was now condemened.

DR. ATHERTON said that as regards safety *that* depended on purity. Hard to get it pure. He believed death came from stoppage of respiration, which occurred before pulse stopped. Recited a case of his own in which tracheotomy was performed, and patient's breathing was resumed. He deprecated the use of brandy before chloroform inhalation. In regard to food given before, better given three hours before than six.

DR. MACFARLANE believed that the heart and lungs stopped simultaneously.

DR. INCHES pointed out that Dr. Atherton did not watch the pulse in the case related. He thought the pulse sounds the warning. Duncan and Flockhart's Chloroform is pure, and can always be had.

DR. GREY said that in his experience the pulse slows first and runs up when administration stopped. Careless administration had something to do with fatality.

DR. MOORE did not attend to either breathing or pulse particularly, but watched all the conditions, and gave no undue importance to either. Extraction of teeth under either ether or chloroform, is a reprehensible practice. Recited cases showing danger of food a short while before. Had assumed no food taken; vomiting ensued, and danger of suffocation for some time.

DR. CURRIE agreed with Dr. Moore's statements.

DR. BROWN had occasion to take chloroform many times, no difficulty till lately. Glass of brandy taken slowly overcame this. Stomach should be empty or at least no food for five hours before.

DR. NEVERS had misgivings in regard to ether. At his first administration in Philadelphia, death had occurred. Since that had always given chloroform. Case given in which chloroform was used in extracting a tooth. Pulse was all right. Respiration stopped, and there was considerable trouble to resuscitate.

DR. COULTHARD, in re heart *v.* pulse, said: In confinements there is little danger from chloroform. Why is this? Diaphragm is called into action to aid expulsive efforts of abdominal

muscles, and respiration goes on regularly, and difficulty he therefore thought was from failure of respiration and not of heart.

DR. CALDWELL had experience as dentist in giving both ether and chloroform, as well as gas. Preferred ether or chloroform when a large number of teeth had to be extracted. Effects more lasting than gas which was suited for short operations only. Does age influence? He thought chloroform less safe than ether in the aged, and *vice versa*.

DR. JONAH related a case of Dr. Pancoast, of Philadelphia. Ether was being administered, those doing so were paying no attention to their duty. Dr. Pancoast noticed cyanosed condition, sprang to his patient, and after much vigorous effort danger was averted. May not death from chloroform in some instances be due to some idiosyncrasy? In some other cases drugs disagree, *e.g.*, tobacco. May not ether and chloroform disagree with particular patients irrespective of purity or careful administration?

DR. WALKER spoke of death in the dentist's chair as due to the chair. Position should be horizontal. In regard to food before using anæsthetics. Two cases of danger from suffocation he related. His practice was to operate early in the morning before food could be taken.

On motion of Dr. Brown, seconded by Dr. Walker, it was agreed to suspend the order of business and decide the place of next annual meeting.

DR. BROWN moved that the Society meet next year in Fredericton. Seconded by Dr. Atherton.

DR. BERRYMAN moved in amendment that the meeting be in Moncton. We ought to meet in different places yearly. Seconded by Dr. McMonagle.

DR. TRAVERS said next meeting would be a very important one, as the members of Council were elected.

DR. NEVERS said that St. John was the proper place to hold meetings, being central, and moved in amendment to the amendment that the meeting be held in St. John. Seconded by Dr. MacLaren.

DR. ALLISON would vote for amendment to amendment, be-

cause St. John was central and meeting important, therefore large attendance was desirable.

The vote being then taken, it was decided in favor of St. John, the vote standing 28 for St. John and 16 against.

AFTERNOON MEETING, THE PRESIDENT IN THE CHAIR.

DR. ALLISON read a paper on "Free-trade in Medicine."

DR. JONAH read a paper on "Hydrocele," advocating the discarding of the painful injection of iodine for the painless and certain one of carbolic acid crystals. (An abstract of this appears in this number of the JOURNAL.)

DR. ALLISON moved that the reading of papers be suspended and new business taken up, as the Fredericton men would leave shortly. Seconded and carried.

DR. ALLISON then moved "that the Council be respectfully requested to furnish each member of the Society annually with a copy of the current register, in any way that may be most convenient." Seconded and carried.

DR. BAYARD, President of the Council, said he had no doubt the Council would do so.

DR. DANIEL read the report of the committee appointed to consider what means may be taken by the Society to assist the Council to induce physicians to register and to prevent unqualified persons practising.

After some discussion, Dr. Addy moved, seconded by Dr. Steeves, that the report be received and laid on the table. Carried.

DR. STEEVES moved that the President be requested to name a committee of three, with permission to add to their number, to consider and report upon, at next annual meeting of the Society, the advisability and practicability of establishing a New Brunswick Quarterly Medical Journal, having the following aims in view: 1st, The establishment of a work that shall be the exponent of the N. B. Medical Society, and also of the views of the individual members. 2nd, The establishment of a channel through which members of the profession may report special medical and surgical cases of unusual interest for the benefit of the whole, it being a well known fact that many highly instruc-

tive, rare cases have occurred among us, and have not been reported mainly because no medical journal was published within a convenient circle. 3rd, The instruction of the public mind on subjects hygienic, through discussion upon questions relating to sanitary laws and regulations. To physicians it is a fact patent enough that few persons have a correct knowledge of sewerage, plumbing or ventilation, and that a still less number know that more than three-fourths of the deaths among children and young persons arise from a want of knowledge upon these subjects. 4th, and finally, It is hoped that there will be diffused through the instrumentality of a spirited journal a greater interest in subjects medical, including medical education.

DR. ATHERTON was afraid funds might not be available.

Motion was then put and carried.

The President appointed Drs. Steeves, Bayard and Atherton that committee.

DR. CURRIE, Registrar of the Council, said that the Council requested those who know of unregistered or illegal practitioners to report them to him, when action would be taken.

DR. MARCH then read a paper on "Plaster of Paris Dressings." (This paper will appear in our next number.)

DR. ALLISON agreed with Dr. March, but thought that in some instances starch or dextrine suited better, *e.g.*, fracture of limbs, where its lightness was preferable.

DR. HAMILTON said that felt was even better than either.

DR. G. P. CALDWELL read a paper on "Fracture of Jaw," with apparatus.

The following papers were then, for lack of time, read by title: "Hip Joint Disease," Dr. M. C. Atkinson, Bristol. "Cases of Puerperal Septicæmia," Dr. J. S. Benson, Chatham. "Diphtheria," Dr. E. Cameron, Grand Manan. "Excision of Tongue," Dr. G. M. Duncan, Bathurst. "Cases," Dr. Jno. Brady, Barnesville. "Tracheotomy," Dr. H. H. Hanson, Andover. "Puerperal Septicæmia," Dr. D. R. Moore, Sackville. "Pneumonia," Dr. J. N. Smith, Hampton. "Treatment Post Partum Hæmorrhage," Dr. G. A. Hetherington, St. John. "Conservative Surgery in Compound Fractures," Dr. MacFarlane,

Fairville. "Meningitis," Dr. T. Walker, St. John. "Surgical Cases," Dr. Atherton, Fredericton. "Venesection," Dr. T. W. Musgrove, Carleton.

DR. COLEMAN then read the report from the Committee on the Tariff of Fees.

DR. CHRISTIE moved that report be received, and taken up section by section. Seconded and carried.

DR. COLEMAN then read the report section by section, each being adopted as read, except fee for Post Mortem, which was made $20.

DR. J. CHRISTIE then moved that the tariff as a whole thus amended be adopted. Seconded by Dr. Allison and carried.

DR. ALLISON moved that the Secretary get a number of copies printed for distribution to each member. Seconded by Dr. Johnston and carried.

The meeting then adjourned, to meet in St. John the third Tuesday in July, A.D. 1884.

G. M. DUNCAN, M.D.,
Sec. N.B. Med. Society.

Extracts from British and Foreign Journals.

Unless otherwise stated the translations are made specially for this Journal.

Good Remedies out of Fashion.—In an address on this subject, delivered at the Annual Meeting of the Metropolitan Counties Branch of the British Medical Association, by the President Dr. C. J. Hare, late Physician to University College Hospital, the lecturer made some interesting observations on emetics and bleeding.

"It is not long ago that, in a very urgent case of bronchitis, I advised the administration of an emetic; when the gentleman whom I had been called to meet in consultation, said: "Why, I never gave an emetic to an adult in my life." In former times, it was not unusual, on the contrary, to commence the treatment of many diseases with the administration of a dose to procure vomiting; and although the remedy might then be given sometimes indiscriminately, and according to routine, only those who have seen the effects of emetics, properly and judi-

ciously given, can conceive the beneficial effects they sometimes produce. In the early stage of an attack of croup, it was by no means unusual to give an emetic of tartarised antimony or of ipecacuanha; and it is in accordance with the recorded experience of some of the best authorities and most practical men, and quite consonant with my own experience, too, that symptoms which presented the most certain augury of a severe attack were by these means cut short, the hoarse voice resumed its natural character, and the feverish symptoms were in a few hours relieved. I know quite well that a great fear is entertained by some as to the depressing effects of emetics; but the fear is theoretical, and not practical, and those who have had most experience in the administration of them best know how groundless the fear is. In diptheria, too, I have seen the false membranes which are out of the reach of local remedies, and which the patients cough and cough in vain, and utterly exhaust themselves to get quit of, readily brought up by the action of vomiting, to the immense relief of the sufferer.

"In suffocative bronchitis, the effect of emetics is sometimes magical, and by their administration in such cases not only is immense relief given, but I verily believe—I am certain—that lives are saved. You are called to a patient who has been ill a few days, with increasing dyspnœa; she is sitting up in bed (I draw from nature), for to lie down is impossible; she is restless and tossing about; the lips, and indeed the whole face, blue; the eyes watery and staring; the pulse quick and small; the cough constant; the expectoration semi-transparent and tenacious; over every square inch of the chest, front and back, from apex to base, you find abundance of rhonchi; moist, sonorous and sibilant ones in the upper part of the lungs, and muco-crepitant or mucous râles towards the bases. Ammonia and stimulants, right and good in their way perhaps, in such a case are too slow in their action; the patient is, in fact, more or less rapidly suffocating. An emetic of twenty-two grains of ipecacuanha in an ounce of water is given; in ten or fifteen minutes, the patient vomits and brings up a huge quantity of that tenacious mucus, and the whole aspect of the case is

altered; the distressed countenance is relieved; the breathing is at once quieter; and the patient is able for the first time for twenty-four hours to lie moderately low in bed, and to get some sweet refreshing sleep. The patient is, in fact, rescued from the extremest peril, and in this case, and in many similar ones, too, I believe, from otherwise most certain death. Of course, in such cases the emetic is not given for its effect on the stomach, but for its collateral effect in mechanically clearing out the enormous amount of secretion which accumulates in the bronchial tubes, and which the patient is otherwise quite incapable of getting quit of; and thus the half-choking, almost asphyxiated, condition is changed for one of comparative comfort, and time is gained for the action of other appropriate remedies. No doubt the secretion may, and often will, accumulate again; and I have not hesitated again in bad cases to repeat the same good remedy; but it is a fact, and a very positive one too, that, quite contrary to what those who have had no experience in the plan suppose, the system rallies instead of being more depressed under the action of the remedy.

"There is a class of cases in which the right heart is engorged with blood, and in which the only hope of rescuing the patient from death is by bleeding. A man of middle age (I again draw from nature) has considerable chronic bronchitis, with some congestion of the lungs, and, like many other unwise persons, he goes to a southern watering place instead of remaining in his room and in an uniform temperature. Becoming worse, he determines to return home, and travels on a cold spring day; his dyspnœa is so much worse on the journey, that his friend and fellow-passengers doubt whether he will arrive home alive; and when his carriage meets him, it is with the greatest difficulty he is conveyed to his house, and got into his drawing-room. You are at once sent for, the message being that the patient is dying, and when you arrive you find that that is the fact. He is sitting in a chair (to lie down is impossible for him), his face is blue and swollen, his lips purple, the eyes suffused and staring, his heavy gasping breathing you have only too distinctly heard and recognized as you ascended

the stairs, and when you see him you find his chest heaving, and each short gasping inspiration followed by a long wheezing and moaning expiration; his lungs are full of moist sonorous, and mucous and submucous rhonchi, and scarcely a trace of vesicular respiration is to be heard, and he is pulseless. He looks to you beseechingly, and gasps out, in scarcely articulate words, that he is dying. This is but too true. Now, the treatment for such a condition at the present day is "to pour in stimulants" (though the patient can scarcely swallow). Brandy and water are given, and ammonia, and perhaps ether; then, if the patient live long enough to have them made, mustard poultices are applied to the chest, and to the calves and to the feet, and the patient is fanned and the patient dies. Something has been done, but that which true pathology—and, indeed, common sense, unshackled by prejudice, custom and fashion—would dictate, has been left undone. Appearances have been saved, but not the patient's life.

"The fact is, that here the danger lay in the right side of the heart being gorged with blood, so that it was impossible for its stretched and distended walls to contract and to propel forwards the thick and blackened blood. Oh, as you value your patient's life, as you value the blessed consciousness of being a minister who has done everything possible for his welfare, let me beg of you not to be contented with the futile treatment of to-day; relieve that poor oppressed distended heart, and all may be well! Open one of those veins which are, with every systole of the heart, tending to carry more and more blood to this already distended right ventricle, and all may yet be well with your patient. Sometimes this blood-letting, in extreme cases, is no easy matter; it may be necessary, before you can effectually open the vein, to place the patient's arm in warm water, so as sufficiently to distend the vein; and even when the ligature has been efficiently applied, and the vein well opened, you may have to press, and squeeze and rub upwards the arm before a drop of the thick and tarry blood will flow. But, when it *does* flow at length freely, oh, what a marvellous change may you see take place!—the breathing becomes quieter,

deeper, and less noisy, the haggard face resumes the appearance of tranquillity, the blueness of the skin is replaced by a more natural tint, the pulse becomes more and more distinct, and, in a word, the choked up heart is set free. This is no fancy picture. Every word is simple truth, and I appeal for confirmation to the memory of every senior member present who recollects the experience of his earlier days, and who can also probably tell you the after-progress of such cases was sometimes almost miraculously rapid, so that in a few days even the patients might become convalescent."—*British Medical Journal.*

Note on Disinfectants.—Dr. W. E. Buck writes: "Most practitioners must have often realized the inefficiency of disinfectants in allaying the fetor of cancerous ulcers, an annoyance which sometimes troubles patients even more than the pain, or the thought of death. I have used the whole round of disinfectants for cancerous ulcers, but all have failed in allaying the fetor, and keeping the ulcer clean. The disinfectants tried were carbolic acid, sanitas, terebene, resorcin, creasote, boroglyceride, chloride of zinc, charcoal, &c. After failure with these, I tried a saturated solution of hyposulphite of soda added to an equal quantity of water, and found it exceedingly efficacious. The ulcerating surface was well syringed and washed with the solution, and was then covered with rags steeped in the solution. The granulations were kept clean, and the fetor was well kept under. Most disinfectants seem to lose their virtue after a few days' application, but I have used this one for months on the same patient with continuous good effects. It is cleanly, has no smell, does not stain, and is very cheap.—*British Medical Journal.*

CANADA

Medical and Surgical Journal.

MONTREAL, AUG., 1883.

TERRITORIAL REPRESENTATION.

This journal has for several years past on every suitable occasion, directed attention to the anomalous manner in which the elections for the Provincial Medical Board are at present conducted. We have also been surprised to find that this matter was not more earnestly discussed by our contemporaries, although as the sequel shows it was one which strongly interested the entire profession. Our readers will have observed by the report of the proceedings at Quebec published in our last number that a motion by Dr. Osler brought the subject before the meeting. It was in effect to give power to the incoming Board to evolve a scheme for having each representative elected by the physicians in his own district, and by them only—to go to the Legislature for an amendment to the Act to that effect—and to carry it into force at the next Triennial meeting. A long and animated discussion took place, a majority of those who spoke favoring the general proposition, but deprecating haste in bringing it into effect. It was finally agreed that the Board should carefully consider the whole question and report thereon at the next meeting. The defects of the present plan of voting were never more clearly shown than at the recent election. That one man with from 125 to 150 proxies in his hand, should be able to elect a candidate who was voted against by nearly every member of his own locality is absurd, and yet we have good reason to believe that such things did actually occur. Such a member cannot by any stretch of the imagination be looked upon as a *representative* of that district. What is wanted is *representation*, and the object

aimed at is entirely defeated by the existing method of wholesale voting. Some would oppose the new scheme, because it takes away from the power hitherto wielded by the cities. We must admit the fact, but would not look upon it as an unmixed evil. Others think that it would involve too great an expense. On this point we cannot speak, but it will of course have to be considered. On the whole, we feel satisfied that the Board will approve of the change, and that the next Triennial will be the last conducted upon the present faulty system.

It is well to remind the members again of the great importance of keeping themselves clear upon the books, and making their payments in due season. The strict letter of the law was in all cases applied, and some who would certainly have been elected were disqualified from want of payment of dues before the legal date. One member who was pronounced disqualified before the election, was reported afterwards to have been fully qualified. He was a candidate and we think would have been elected. If our information is correct, the case is one of considerable hardship. Mistakes may of course happen, but the entries in the official register are so important that it comes very hard to excuse blunders which cause such serious consequences—consequences which it is impossible subsequently to remedy.

ROMA LOCUTA EST. CAUSA FINITA EST.

The end has come. The fiat has gone forth. The ultimatum has been reached. The Church has spoken, and its firm decree can never be recalled. The Medical Faculty of Victoria University, or the Old School of Medicine and Surgery, of Montreal, is virtually a thing of the past. They were long ago instructed to commit suicide, annihilate themselves and disappear. Having refused to do so, their execution was decided upon, and now the axe has fallen. After many delays, after appeals to bishops and to Rome itself, at last the full power of the Roman church has been called into effect, and the faithful have been notified from every parish pulpit, that the most unquestioning obedience is called for.

For the benefit of those of our readers who may not have followed the course of the controversy between the opposing schools of Laval and Victoria, in this Province, we make the following abstract from the *mandement* of Bishop Fabre, of this diocese, which recapitulates the case from the time when instructions were first issued that Laval should be supported. He regrets that some Catholics have still continued to act contrary to the spirit of this official declaration. He next states that an opportunity was given the professors of Victoria to effect an amalgamation with Laval University and retain their positions. This was declined. The next move was to order the Sisters of the Hotel Dieu to refuse admission to all professors and students except those attached to the one recognized University. The ladies appealed to Rome, the unrecognized teachers to a Committee of Provincial Bishops. The latter have confirmed the pretensions of Laval—the following extract from their report shows how completely: "No Catholic can conscientiously form part of the said school (Victoria) or attend the lectures, and the professors and students cannot be admitted to the Sacraments of the Church." Rome simply reiterated its commands to the nuns. They have, of course, submitted and shut their doors upon their *quondam* staff. His Lordship is of opinion that by these decisions "eternal welfare is offered to our studying youth." Parents and guardians are warned that in encouraging any opposition to the decrees on the part of students, they are "inoculating them, and that for life, with the virus of prejudice and bad faith." The reason why the church *should* be allowed full authority in *all* matters of education, secular and other, is thus given by the Bishop at the conclusion of his address: "It is without doubt our salvation that comes to us from Rome; it is the salvation of our society, because it is the guarantee of a Christian and solid education, and as we all know, education is the basis of society."

It is a strange sight in this latter half of the 19th century, in a free country, to see an old and well-established, numerously attended, medical school wiped out of existence by a higher power, in spite of its most strenuous efforts to maintain a separ-

ate existence. Notwithstanding all the liberalism which has crept into men's ways of thinking, the terrors of the church in a thoroughly Catholic country like this, are a real power.

Rumor has it that the Old School will re-open as usual. We do not see how this is possible. They have no longer a hospital, and can students withstand the pressure that will be brought to bear upon them to bring them within the fold of Laval?

M. SOUVIELLE CAUGHT IN THE ACT.

The public has been made aware of the return of M. Souvielle, the Proprietor of the Lung and Throat Institute, and his doings in Europe. Almost every newspaper (in which his advertisements appear) has had laudatory puffs about the tin-pot inventor. In none of them, however, do we find any reference to the following interesting transaction which shows to what length this person has gone to get a qualification. In the London *Lancet* of June 30th, appears the following editorial item:—

"An official announcement at the University of Erlangen, states that one Matthew Souvielle, from Montreal, has attempted to obtain the doctorate by palming off as an original dissertation an essay on Diabetes, by Dr. Bürgel, which appeared in *Deutsches Archiv fur Klin. Medicin* in 1873. The would be graduate performed his imposture somewhat clumsily, for he neglected throughout the essay to substitute English names for the German ones. He had, however, converted "Professor Liebermeister" into "Professor Spencer."

NEW BRUNSWICK MEDICAL SOCIETY.

Through the kindness of Dr. Duncan, the Secretary, we are able to present our readers with an interesting report of the annual meeting of the New Brunswick Medical Society. By the provisions of the New Brunswick Medical Act of 1881, all persons who register under the Act constitute the Provincial Medical Society. The Council appointed to carry out the Act consists of nine members, five of whom are elected by the Medical Society and four nominated by the Governor-in-Council, so

that the Society has an important function in addition to the promotion of the general welfare of the profession, and is more closely connected with the State than other Canadian associations.

The suggestion of Dr. Steeves to establish a journal is one which we should like to see carried out. The Maritime Provinces are quite able to support one, and from what we know of the general professional attainments of the practitioners in those parts, a journal devoted to their interests should not suffer from lack of original communications. It is true the "Provincial Medical Journal," started in Halifax in 1868, was not long lived, but in the past fifteen years a great change has come over the profession, and the members are more alive to the necessity of supporting associations and journals. There are nearly six hundred medical men in Nova Scotia, New Brunswick, and Prince Edward Island, and a quarterly or bi-monthly periodical should receive ample support, and with a subscription list of three hundred, and a fair share of advertising pages, would pay expenses.

WHAT NEXT?—We have long been satisfied of the utter inefficiency of our present Health Board, and quite recently some (as Mr. Boxer, a member) have spoken very plainly on the subject. One would naturally suppose that the city authorities themselves, and the Health Officer particularly, would be the parties to be looked to in such matters. Not so, however, we have in this Province only one man who can do anything. Is it necessary to say that we allude to the "great uncrowned," "His Excellency," Chevalier Senecal? He has arrived from Europe, where delighted capitalists vie with each other in pouring money into his lap. He has spared a few moments from his great railway, beet root, land and lumber schemes to look round this city; has found its sanitary state very bad; has delighted our Health Officer by telling him that he is interested in this matter, and will introduce him to some wealthy French capitalists seeking information on the climate and resources of this country. This scheme is an excellent one. It will cause the worthy Dr. Larocque to find himself in excellent company, on which we congratulate him. But how that

is going to help clean our dirty backyards, or promote an efficient sanitary system in our midst, it might be difficult to say. Still, though our Anglican stupidity may prevent our seeing this, a large section of the public will now be perfectly satisfied. Has not Senecal said that he is interested in the muddle of our Health Office? And is it not enough for him to see an unsolved problem to solve it?

CANADA MEDICAL ASSOCIATION.—The sixteenth annual meeting of the Canada Medical Association will be held in Kingston on the 5th, 6th and 7th of September, under the Presidency of Dr. Mullin of Hamilton. The Local Committee has made the necessary arrangements, and a large meeting is anticipated. The usual reductions will be made on railways and steamboats, and the necessary certificates will be forwarded on application to the General Secretary, Dr. Osler, Montreal.

Personal.

Henry O'Keefe, M.D. (McGill, '82), is in Minto, Dakota.

Dr. Orton, M.P., of Fergus, Ont., has removed to Winnipeg.

S. S. C. Phippen, M.D. (McGill, '83), has settled in Owasso, Mich.

J. Simpson Lathern, M.D. (McGill, '83), has passed the L.R.C.P., London.

Charles E. Cameron, M.D. (McGill, '83), has passed the M.R.C.S., Eng.

C. E. Lamirande has been gazetted Inspector of Anatomy for the Montreal district.

F. H. Mewburn, M.D. (McGill, 1881), House Surgeon to the Winnipeg Hospital, was in town this month.

W. A. Shufelt, M.D. (McGill, '81), has given up practice at Brome, Q., and has gone to England to pursue his studies.

Dr. George Ross and Dr. Buller have gone to the Northwest for a holiday trip, and will return about the 7th of September.

Capt. Webb, the celebrated swimmer who lost his life in the Niagara Rapids, was the son of Dr. Thomas Webb, of Cheadle, Staffordshire.

J. B. Lawford, M.D. (McGill, '78), has been appointed Registrar and Chloroformist to the Evelina Hospital for Sick Children, London.

Dr. John Marshall, the Surgeon and Physiologist, succeeds Sir Spencer Wells, Bart., as President of the Royal College of Surgeons.

Dr. Calvin Ellis has resigned the Deanship of the Harvard Medical School, and Dr. H. P. Bowditch has been elected in his place.

W. J. Prendergast, M.D. (Bishop's, 1882), late House Surgeon at the Woman's Hospital, is about to begin practice at the east end of the city.

Dr. Riddell has resigned the coronership of Toronto, a position which he has filled for many years. Dr. J. T. Duncan has been appointed associate coroner.

Dr. Strange, of Toronto, and Dr. F. W. Campbell, of Montreal, have been appointed Surgeons to the Militia Schools of Instruction in the Provinces of Ontario and Quebec.

Dr. Reginald Southey, one of the Assistant Physicians at "Barts" has been appointed a Commissioner in Lunacy. As he is not a specialist in this department we may expect an outcry from the alienists.

The retirement of Dr. John C. Dalton, from the Chair of Phisiology in the College of Physicians and Surgeons, will be universally regretted; all the more on account of the reasons, ill health, which have led to it. Dr. J. A. Curtis succeeds him.

Dr. Pitman, Registrar of the Royal College of Physicians, London., Mr. Saunders, Surgeon Dentist to the Queen, and Mr. Porter, of Dublin, one of the Surgeons to the Queen in Ireland, have been knighted. Dr. Banks of Dublin declined with thanks.

Reuben Levi, M.D. (McGill, '77), M.R.C.S., Eng., late of Inverness, P.Q., has returned from Europe, where he has been studying for nearly two years. Dr. Levi intends moving to the larger sphere of New York, where his ability and perseverance will in time command success.

Dr. Thomas Dwight has succeeded Dr. Oliver Wendell Holmes as Parkman Professor of Anatomy in Harvard. The appointment is in every way a suitable one. Dr. Dwight, who is a grandson of Dr. J. C. Warren, whom Dr. Holmes succeeded

in the chair, has been well known for some years as an original worker in Anatomy, and has published some important memoirs and papers.

Medical Items.

—Joseph Bell, a leading Edinburgh surgeon, is dead.

ECONOMY.—The annual grant of $750 dollars made by the Provincial Government to each of the Medical Schools of the Province has been reduced 33⅓ per cent.

—Oliver Wendell Holmes says that the great secret of success in every form of quackery is hope kept alive in the patient; while the too fatal gift of science is a prognosis of despair.

—Dr. Liddell, of New York, died suddenly on the 8th July. During the war he was Inspector-General of the Army of the Potomac. His name is well known in connection with nervous diseases.

—Most of the cheap cigarettes now flooding the market contain proportionately more nicotine than an ordinary cigar. One reason for this is, that many of them are made from cigar stumps, which contain the nicotine of the entire cigar.

—One person out of every five in the United States has one or more corns, and the cost of effecting a cure is $1.30. What is the number of corn victims, and what would be the cost of placing every person on a sound footing?

—Dr. Kingman, in the *Boston Med. and Surg. Journal* of July 14th, calls special attention to the advantages of Prague for the study of Obstetrics. A new departure by several of the assistants is to give clinics in *English*. This will be done in the latter part of the summer, if sufficient English-speaking students shall warrant it.

—Dr. L. J. Lennox, of the International Throat and Lung Institute, Toronto, has brought suits against Dr. McCammon of Kingston and Dr. Bray of Chatham. The writs claim $10,000 each for damages for slander spoken by the defendants of the plaintiff at the last meeting of the council in that city, in his connection as proprietor of the "spirometer," calling him a quack, a medical prostitute, &c.

—At a meeting of the Board of Trustees of the Women's Medical College, Kingston, the following were appointed professors:—Obstetrics, Dr. M. Lavell; Surgery, Dr. M. Sullivan; Anatomy, Dr. C. Irwin; Materia Medica, Dr. A. S. Oliver; Practice of Medicine, Dr. H. Saunders; Medical Jurisprudence and Sanitary Science, Dr. T. M. Fenwick; Institutes of Medicine and Histology, Dr. W. H. Henderson. The college will be opened in October.

—In the crowded railway carriage. First traveler: "I say, do open that window there, or I'll suffocate!" Second traveler: "Don't you open that window there, or it'll give me an attack of pneumonia." First traveler: "That makes no difference! If you have pneumonia, you won't have it for a week, whereas if I am suffocated, I'll be suffocated now. Open that window there."

THE BLESSING OF QUININE.—The traveller here soon learns to duly appreciate the value of cinchona. Take away its alkaloid extract, quinine, and in less than two generations the low lands of Central America would relapse to barbarism; without this precious safeguard, steamship lines would never have been established here, nor would Northern engineers have been able to penetrate the tangled fastnesses of the dense woods, to survey routes for railroads. Hence medicine, in the discovery of the virtues of Peruvian bark, has contributed the most potent factor towards the advancement of civilization in these regions where nature so stoutly resists its progress. Humboldt, in his "Ansichten der Natur," shows that this discovery is wholly due to our profession; for instead of its being an aboriginal remedy, he found in his travels among the Andes that the Indians, when attacked with fever, could not be persuaded to take this Peruvian bark.—*Dr. L. C. Lane on Guatemala.*

Physicians' Account Books.—We received a short time since from W. Benj. Plow, at John Lovell & Sons, a set of two books specially prepared and ruled for the use of physicians. The one is a day book and the other a *resumé* of the whole, or ledger. We have made trial of them, and can strongly recommend them to others as being very convenient, and saving a wonderful amount of writing and trouble in the posting of their books, and preparing half-yearly accounts. They may be had for a small sum by applying to the above address.

CANADA

MEDICAL & SURGICAL JOURNAL

SEPTEMBER, 1883.

Original Communications.

IS PNEUMONIA INFECTIOUS?

By GEORGE WILKINS, M.D., M.R.C.S., Eng.,
Professor of Medical Jurisprudence, McGill University; Physician to Montreal General Hospital.

There are but few physicians of even only a moderately large practice who, through peculiar circumstances, can have failed to ask themselves the above question on some occasions. It is the experience of each of us to have a much greater number of pneumonic cases at certain seasons of the year, so that, collectively, the disease is very prevalent at that particular time. It then forms a high percentage of prevailing diseases as compared with other seasons, and certainly has the appearance of being, to some extent, dependent on the sudden changes of temperature. But cases of pneumonia do frequently occur with which climatic changes in temperature cannot possibly have anything whatever to do. So, also, a not at all unusual circumstance is the occurrence under the same roof of two, three, or four cases of pneumonia, all of which cannot be considered the results of cold. Then the above question forces itself upon us. Friends of the patients will put the question—"What is it, doctor?" "Is it something taking?" Such was my experience four years ago, and, I feel certain, must be the experience of other physicians also.* To reply unqualifiedly "No," with our present know-

* Dr. Bell, Medical Superintendent of the Montreal General Hospital, has kindly furnished me with a synopsis of the report of four cases that he met with, which he has permitted me to make use of, and which are embodied in this paper, together with four cases of my own, which we believe to be altogether independent of climatic changes of temperature.

ledge, would scarcely be quite correct. The views of the more important writers on this subject are widely different. Whilst some maintain, as of old, that all cases of pneumonia are the effects of cold, others are equally decided in their opinion, indeed more so, that all cases of pneumonia are of an infectious nature. Others, again, believe that both views are too exclusive, and that really two distinct forms exist. Without committing ourselves decidedly to any one of these views, we cannot help thinking that clinical experience appears, at any rate, to support the latter view. That there is an infectious form of pneumonia there can be little doubt. Hirsch and V. Ziemssen long ago advocated this theory. The evidences in support of such a view are of so convincing a nature, and, now that attention is being drawn to the question, are accumulating so rapidly, that we propose placing before our readers a synopsis of some of the more important ones brought forward. This evidence is of a two-fold character. On the one hand, we have histories of epidemics that can be accounted for only on the ground of the existence of a specific poison. On the other hand, we have microscopical investigations which, though as yet incomplete, even in this state add great weight to arguments derived from these epidemics. To refer first to some of the epidemics recorded.

The evidences of the occasionally epidemic character of pneumonia are so strong that even the most skeptical must admit it. Langer* quotes from Laveran† an epidemic which broke out on board the ship *Saint Jean d'Arc*, in mid-ocean, during the months of June and July, 1860, during which time fifty cases occurred. By the commencement of October, 86 men had been attacked. The disease disappeared from this vessel only after transference of all the sick to another ship. In 1861, when this same vessel was again manned, the disease returned with increased virulence, necessitating disembarkation at Plymouth. Butry‡ mentions the occurrence of an epidemic of pneumonia

* Wiener Medizinische Wochenschrift, 1883, Nr. 27, Seite 842.

† Gaz. hebdom., 1865.

‡ Deutches Arch. f. Klin. Med., xxix, s. 193, quoted by Centralblatt f. d. Medicin. Wissens., 1882.

that took place in a small village (Bekerbach) of 460 inhabitants, of whom 20 persons (4 per cent.) contracted this disease, and of whom 9 died. In none of the villages around were there any cases of pneumonia. He mentions, amongst others, the case of the son of a miller who contracted the disease away from his father's house, and was brought home to the mill, in which, subsequently, the father, mother, and a grandchild contracted fibrinous pneumonia. Scheef,* an assistant of Jürgensen's, mentions an epidemic of pneumonia that occurred in the village of Lustnau (1,633 inhabitants). For the nine years previous to the occurrence of the epidemic there were 29 cases in all; from January to May of 1881, there were 44 cases; from the latter date up to the following November, there was not a single case. In quite a number of houses in which pneumonia occurred in this epidemic, there had been, within the last four or five years previously, occasional cases of the same kind. In this epidemic the mortality was very high (33 per cent.) At the autopsies, the inflammation was found not limited to one lobe, nor even to the lungs. In many of the cases, parenchymatous inflammation of other organs was present, pointing, as the writer believed, to a powerful infecting cause.

Penkert† describes an epidemic of pneumonia occurring in a small village of 700 inhabitants (Rieth-Nordhausen). The source of the disease was considered to be the miasma from a well into which water flowed from a church-yard. In all, 42 individuals were affected within the space of two months.

Köhnhorn reports‡ 321 cases as having occurred in Wesel garrison during the space of eight years. The result of his experience is a complete denial of cold as being a cause of croupous pneumonia. He regards it as an infectious disease. So, also, does Dr. Bary, physician to one of the largest hospitals in St. Petersburg. During the last 30 years he has attended personally over 700 cases of pneumonia. From his study of these

* Jürgensen, Croupose Pneumonie. Beobachtungen aus der Tübinger Poliklinik. Tubingen, 1883.

† Berlin Klin. Wochenschrift, 1881, No. 40.

‡ Vierteljahrsschrift f. gericht. Medicin., 1881, s. 81.

cases, he does not consider that there can be the slightest doubt it is an infectious disease, and that the inflamed lung is simply a local symptom.*

Dr. H. Schmid reports† an epidemic which occurred in a small village (Zang) of 549 inhabitants, in which 19 individuals were attacked with croupous pneumonia. The first one took ill on the 5th of April, 1882; the second on May 11th, and between that date and the 11th of July, 18 others contracted the disease, when it quite disappeared. Amongst the lot were six cases in one house and in the same family. The cases are so interesting that I will mention a few of the more important circumstances related by Dr. Schmid. The family was one of the poorest in the village, and all slept in a room over the cow-stall. The family consisted of the man and his wife and six children. Of these eight, as I have just stated, six took ill. The first, a child 18 months old, died on the 24th May; on the 27th, a child, 5 years old, commenced to improve on the tenth day; on the 13th June, a boy aged 11 years sickened, and after four days commenced to improve; on the 15th, a child aged 9 years contracted the disease; on the 19th of June the father and a child aged 3 years took ill. The three last mentioned were ill only four days. In all these cases, as well as in the others, there was cough, pain in side, high temperature, rapid breathing, besides other physical signs of pneumonia more or less marked.

As I have stated in the earlier part of this paper, Dr. Bell and I have each of us had four cases, which can be accounted for, only on assuming the contagious nature of this disease. A short report of the cases occurring in my practice is as follows:

On the 4th May, 1879, I was called to see Mrs. M., who expected her confinement in the middle of the month. Her friends thought possibly labor was setting in. On my visit I found her with rapid pulse (124) and high temperature (104.2°), frequent respirations and slight cough, complaining of headache,

* Vierteljahrs f. Gericht. Med. u. Offentliches Sanitats. July, 1883. Seite 117.

† Berlin Med. Wochen., 1883, s. 346.

but no labor pains whatever. I suspected pneumonia, although examination revealed nothing, prescribed Liq. Ammon. Acetat. and Tr. Aconit., and warned her friends that labor might set in at any moment in consequence of the high fever. Within twelve hours labor pains had commenced, and in three hours after she was delivered of a fine healthy child. Now for the first time she complained of pain in right side, had bloody expectoration, subsequently becoming rusty-colored, and all the physical signs of inflammation of the base of right lung, which subsequently extended, involving the entire lung, accompanied with extensive consolidation. Evening temperature never went below 104°. On the fifth and sixth day of the disease it was 105°, and at 9 a.m. of the sixth day reached 106°. At 1 p.m. and 5 p.m. of the same day it was 108°, patient dying at 7 p.m.

On the 5th May, a child of hers, aged 6 years, took ill, with high temperature (103.4°), rapid pulse, and the physical signs of pneumonia. This child commenced to improve on the sixth day of its illness.

On the 9th May, Mrs. M.'s mother, aged 75 years, who lived in adjoining house,* but under the same roof, took ill with rigors, fever, cough, rusty sputum, and marked dullness over the entire right lung. With this patient the mental faculties were interfered with. She lay like a patient suffering from septic poisoning—in a half stupid condition; whereas Mrs. M.'s mind was clear up to within one hour of her death. This old lady died on the fifth day of the disease.

In neither of these cases was an autopsy permitted to be made.

On May 25th, I was called to see Mr. L., son-in-law of the last patient, and who lived in the same house. He had had a severe rigor on the previous evening. On examination, I found base of left lung consolidated, temperature 104.2°, pulse 112,

* This was practically one house, as the two houses communicated by a common porch over back doors, and there was constant intercourse between the two families. A point which may be of some importance in connection with Jürgensen's and his assistant's theory, that it is a ground or house disease (Hauskrankheit), is the fact that this building contained four tenements, two up-stairs and two on the ground flat. The cases of pneumonia were limited to the families on the latter flat. The house is an old-fashioned one, with this flat built close to the ground, and no windows to the cellar to permit of ventilation of the ground.

respiration 36. I immediately placed patient on large doses of quinine (20 grains), subsequently increased to 30 grains, but without any marked effect. On the 31st May, with the approval of Dr. Roddick, who saw patient in consultation with me on three occasions, 20-grain doses of soda salicylate were given every two hours for four doses. Although both temperature and pulse were brought down (temperature 99°, pulse 100), respirations increased to 46. On the 1st June temperature rose to 103°, pulse 122, respiration 40, when four more doses of the salicylate were ordered. From the condition of my patient after he had taken the 80 grains of salicylate, I determined never again to prescribe it as an antipyretic in pneumonia. At 11 p.m., six hours after last dose, he was in an alarmingly prostrated condition—unable to move or speak above a whisper, breathing rapidly, with a feeble pulse of 146, indeed in a condition of collapse. On large doses of stimulants he commenced to improve. On the 2nd of June crepitation was discovered in apex of right lung, rapidly extending downwards, with accession of other symptoms of pneumonia. On the 6th of June symptoms commenced to improve, and on the 17th of the same month the physical signs had quite disappeared. Patient was a long time convalescing.

I see that Jürgensen, in the brochure lately published, to which reference has already been made, says that salicylic acid is not suitable for treating the fever of pneumonia on account of its depressing action on the heart. My experience in this case of its action as an antipyretic in pneumonia is quite in accord with his; so much so, that I have never attempted it since.

Dr. Bell summarises the report of his cases as follows:—

On the 13th of March, 1880, I was called to see Harry B., aged 38 years, a former Hospital servant, and a hard drinker. He had gone to his work in a cigar factory in the morning, feeling quite well, but about noon he had a severe rigor, followed by a sharp pain in his left side. He came home at 1, and I saw him about 6 p.m. There was then cough, with rusty expectoration, severe stitch-like pain, hurried and labored breathing, and a body temperature of 105°F., with fine crepitation over a considerable area of the lower half of the left lung. I had him

removed to Hospital immediately. Here he passed through a severe attack of typical sthenic pleuro-pneumonia, with rapid and extensive consolidation of the lower portion of the lung. The temperature fell suddenly about the eighth day, but rose again gradually in a day or two, and very soon the left pleural cavity was found to be moderately filled with serous effusion. This disappeared gradually, however, without tapping, and he was discharged in good health on the 1st of June, having been eighty days in Hospital.

On the 14th of March, the day following the admission of the last patient to Hospital, I was called to see A. B., aged 35 years, a relative of his, who worked in the same factory and lived in the same house with him. I found that he had been attacked in a similar manner, and had a well-marked pleuro-pneumonia. He was removed to his home, and passed safely through a severe attack, terminating by critical defervescence and rapid recovery.

On the 18th, four days later, the wife of the first patient, Emma B., aged 30 years, was attacked suddenly with stitch in the side and chill, followed by all the symptoms of pneumonia. She came to Hospital on the following day, with consolidation of the lower half of the left lung, and passed successfully through a typical severe pleuro-pneumonia, with critical defervescence on the sixth day, followed by speedy recovery.

On the 19th, the day on which the last patient was brought to Hospital, her brother, aged 20 years, who also worked in the same cigar factory as her husband, and who was now the sole remaining member of the household, was attacked just as the others had been towards the close of the day, and came direct to Hospital. He was admitted, and passed through a very severe attack of pneumonia, with specially severe pleuritic symptoms. The disease terminated favorably, as in the other cases, by critical defervescence.

It will be observed that in a household consisting of only four persons, three of whom worked in the same cigar factory, all were attacked within a week with pleuro-pneumonia, and that the mode of onset, course and termination of the disease was precisely similar in all, the prominent symptom being pleuritic

pain, followed, in the first case only, by effusion into the pleural cavity. On referring to the Hospital books, I find, also, that during the ten days from the 13th to the 23rd of March, 1880, eight cases of pneumonia were admitted.

Dr. Ritter* of Zurich has written a most exhaustive article based on seven cases which occurred in his practice. Their history is, in many respects, very similar to that of Dr. Bell's cases and mine. The disease commenced in the house of a relative of his. Two brothers, his sister-in-law, a maid, and another servant, all of whom lived in the same house, sickened within five days. Five to six days after, two other individuals sickened in the same manner. Three of these patients died, on all of whom an autopsy was made by Prof. Eberth. The anatomical alterations in all were limited to the lungs, with some slight swelling of spleen and kidneys; stomach and intestines perfectly normal. Ritter traces the infection to a room in his brother's house in which a number of birds were kept, but as birds had been in this room for some years and no disease arisen, he considers the infection to have been imported. About a fortnight before the breaking out of this "house epidemic," as he calls it, some birds had arrived from Hamburg, and at about the same time another case from Vienna, and both were unpacked in this room. To either of these he attributes the source of infection. Every one of his patients had spent more or less time in the same room.

One of the most important and instructive contributions to the literature of pneumonia is the work already referred to by Jürgensen and his assistants. The "Poliklink" embraces a working district of about 4,000 souls, in which this institute possesses the monopoly of medical treatment. Between the years 1873 and 1881 inclusive, over 500 cases of pneumonia were treated and autopsies made on all the dead. Keller, who writes one of the sections of this work, regards the disease as an infectious one, which has its origin, like ileo-typhus (typhoid fever), from the under-ground of dwellings. He looks upon pneumonia as a house disease (Hauskrankheit). Just as typhoid fever has a predilection for certain houses, so also does pneumonia occur in

* Deutches Archiv. f. Klin. Med., Bd. XXV., seite 53.

certain dwellings. In referring to the old doctrine of cold being the cause of pneumonia, he thinks that catarrh of any kind, which may be the result of a cold, will favor the implantation of the pneumonic parasites, just as a small wound will be a favorable opportunity for the reception and growth of the erysipelas cocci.

Sir Wm. Jenner,* as far back as 1874, was so convinced of the existence of a contagious pneumonia that he opposed the opening of a drain in a school at which two of his sons attended. He assigned as a reason the probable danger of pneumonia occurring in consequence of the escape of sewer gas. Notwithstanding his protest, the drain was opened. On Friday, March 20th, a high tide in the Thames blocked up the mouth of the sewer, and the compressed gases forced an opening through the ventilator. Next morning, a boy sleeping in one of these rooms was taken seriously ill with pneumonia; on the evening of the same day, two other boys and two servants became similarly affected. One of the servants ultimately died.

Had the pneumonia here been due to the incident mentioned, that is, the blocking up of the sewer, the occurrence of a case of pneumonia next morning would imply an incubation period of much shorter time than is generally admitted. In Ritter's cases the time varied from 9 to 14 days, although he, as well as others, quote as short a time as three days. In Sir Wm. Jenner's cases, it is more than likely some of the gases had escaped into the room previous to the incident referred to.

Langer,† physician to one of the hospitals at Vienna, does not quite agree with Jürgensen and his pupils. He supports the view that there exists two distinct forms of pneumonia—that is to say, ætiologically speaking. He does not, however, consider that there is any difference in the anatomical seat of the disease, nor in the pathological processes. He, however, quite agrees with Jürgensen that the infectious form of pneumonia is a "house disease." He mentions a most interesting fact, that most of the cases that came under his care in hospital were brought from

* Lancet, Sept., 1878, page 419.

† Wiener Medizinische Wochenschrift, 1883, Nr. 27, Seite 842.

den, to which I will refer directly. An interesting fact mentioned by Friedlander is that neither in the alveoli of the lungs nor in the tissues of the pleura do they occur in the form of colonies. In greyish-red hepatisation, many hundreds, sometimes thousands, of these small parasites were found within a single alveolus. Although absent in the walls of the alveoli, and also in the walls of the bronchi and blood-vessels in most of the cases, they were found in one of the cases in enormous masses in the lymph-paths of the interstitial connective tissues, especially those paths which led from the hepatized region to those alveoli which contained air. Friedlander appears to attach much significance to this fact. Micrococci could arise from the dead substances of the fibrin in the fibrinous masses of the bronchi: such an origin he does not believe to be possible in the exudation into the alveoli. Their presence in the lymphatics, however, is an unquestionable proof that they can have no such origin. The "capillary emboli" described by earlier writers as occurring in malignant endocarditis, puerperal pyæmia, &c., Friedlander, agreeing with V. Rechlinghausen, says are micrococci. The varicosed capillaries so frequently met with in these conditions can only be due to a substance which is capable of growth.

Quite recently an interesting and most instructive discussion on infectious pneumonia took place at a meeting of the Medical Society at Berlin. The subject was introduced by Professor Leyden,* who described these organisms very much as Friedlander had previously pictured them—as *cocci* of an ellipsoid form, their length amounting to almost one micromillimeter, their breadth about one-third less. For the most part they are found in couples, hence called *diplo-cocci*. Leyden introduced a hypodermic needle into the hepatized lung and withdrew a small quantity of blood and exudation, and was able to demonstrate these parasites in a tolerably large number. On two occasions, in which the inflammatory trouble was of but a slight nature, he could find no micrococci. In one case, which resulted in death, a small quantity of the exudation was scraped off the cut surface of the hepatized lung on to a glass slide and examined after staining. They were most abun-

* Zeitschr. f. Kl. Med., VI., 1883, Seite 267.

dant, especially so in red hepatization. They resembled those found during life, of an oval shape, united so as to form diplococci, and occasionally in chains of three to four joints. Sections of the lung, hardened in alcohol, were also examined, and these parasites found in them also.

Dr. Gunther mentioned the case of a man, 48 years of age, brought into the Berlin City Hospital in an unconscious condition, ill previously nine days. A physical examination showed marked dulness of right lower lobe, but on account of the difficult breathing of the patient it was impossible to decide whether he had here a case of pneumonia, pleurisy, or pleuro-pneumonia. To determine the true nature of the trouble, he introduced the hypodermic needle into the dull area and withdrew a few drops of a cloudy, sanguino-purulent mass. When examined microscopically, besides containing a large number of lymphoid cells and red blood corpuscles, there was present a very large number of actively moving diplococci of an elliptical form. After death, which took place five hours after his being brought into hospital, the whole of the right lower lobe was found hepatized—partly grey, partly greyish-red—and the pleural cavity obliterated. Dr. Gunther supplemented his remarks by showing, under the microscope, a preparation taken from this case. Köbner, who saw this preparation, said it reminded him of micrococci which he had discovered, in 1872, in blood and serum of animals which subsequently died during the epidemic of that year of the well-known *peri-pneumonia bovum.**

In two of Ritter's cases Eberth states that micrococci were present in the exudations partly scattered and partly grouped so as to form colonies; in one of the cases the lymphatics of the pleura were completely filled with the micrococci.

Ziehl,† assistant physician to Prof. Erb, professes to have dis-

* Whilst this paper was in the printer's hands I received the August number of the *Archives de Physiologie*, in which is a paper by MM. Cornil and Babes on *Peripneumonie Contagieuse* of cattle. The seat of the micro-organisms, they say, is in the subpleural and interlobular connective tissue and in the lymphatics of the lung. They consider the histological lesions of the lobular pneumonia of measles, analagous in many respects to those of the cattle disease. These observers describe a micro-organism present in the secretions of the respiratory mucous membranes, which they consider characteristic of measles and the carriers of the infection.

† Centralblatt f. d. Med. Wissens, 1883, S. 433.

covered micrococci in the sputum similar to those described by Friedlander as characteristic of pneumonia. That characteristic micrococci should be found there is what we should expect, knowing the source of the sputum—that is to say, if such characteristic micrococci or diplococci really exist. He, however, qualifies his statement that the round form are of more frequent occurrence.

Litten,* about eight or nine months ago, described a form of pneumonia which he calls "contusions-pneumonia." This, he says, frequently makes its appearance two or three, or even several days after receipt of an injury, patient being quite able to work during the interval, until he comes under treatment for the pneumonia. He says that it frequently arises without injury of the bones or any affection whatever of other organs. Ziehl refers to this class of cases, and thinks it quite possible that the presence or absence of Friedlander's micrococci may help to determine whether the lung affection is of an infectious nature or due to trauma.

Quite recently Griffin and Cambria have published † the results of inoculation experiments performed by them on forty animals. The material made use of was taken from five patients suffering from croupous pneumonia, and consisted of expectoration ‡ and of the blood taken from these individuals. The conclusions they arrived at as the results of these experiments are, that pneumonia is not an infectious disease. Their inoculations resulted invariably in fatal septicæmia, but no pneumonia. Their conclusions, however, cannot be accepted, as they do not appear to have inoculated with the exudative material described by Leyden, withdrawn from the living lung.

To draw conclusions such as these experimenters have done from negative results is, to say the least, unreliable. No one doubts the infectious nature of typhoid fever, yet we have the authority of Klein § for stating that no one has as yet succeeded

* Zeitschr. f. Klin. Med., Bd. V., Seite 26.

† Résumé published in Archives Italienne de Biologie, tome III., p. 189.

‡ They profess to have discovered a special bacillus in both the blood and expectoration of pneumonia, different from the monads described by Klebs as existing in the exudation of pneumonia.

§ Report of the Medical Officer of the Privy Council, 1875, p. 83.

in transmitting it to the lower animals. He has experimented on monkeys, guinea-pigs, rabbits, dogs, cats and white mice, and all without success.

Should these Italian scientists experiment on similar animals as those they used in their pneumonia investigations, with the pus from a hard chancre, they would be quite as unsuccessful in producing the specific disease. Prof. Köbner,* of Berlin, and Prof. Neumann,† of Vienna, have performed numerous experiments on various animals, and so far have not succeeded in transmitting syphilis from man to animals, although with the pus from soft chancres inflammation of the lymphatics is produced. So that to draw conclusions that pneumonia is not an infectious disease, simply because it has not yet been demonstrated to the satisfaction of all that the disease is dependent on, or associated with, the presence of some specific parasite, or that it can be inoculated, would be extremely erroneous.

THE PLASTER OF PARIS DRESSING.

By J. E. MARCH, M.D.

(*Read before the New Brunswick Medical Society, July* 18, 1883.)

Mr. President and Gentlemen,—It is not my intention in this short paper to bring in review before you the history of this immoveable dressing, nor yet to take one side or the other in the controversy as to who first applied it with peculiar success in a particular class of diseases. Rather, I propose to give you an account of my own experience with it, and to state to you, as simply and briefly as may be, the indications for, and the results to be expected from, its use. To this end I purpose answering three questions—When, why and how shall I use it? Before answering these questions directly and particularly, it may be well to consider them generally by means of a few cases taken from my note-book.

Case I.—In June, 1880, I was called to see F. W., a girl,

* Wiener Medezinische Wochenschrift, No. 26, Juli 21, 1883; pp. 897, 903.

† Neumann, in referring to the statement of Klebs ond other observers who have asserted the transmissibility of the syphilitic virus to the animals, says that they must have made use of the pus of the soft chancre.

aged 14. Her father stated that a month or six weeks previously she had complained of pain in her back and abdomen, which had up to this time been growing continually worse. The pain in the back was not always present. The pain in the abdomen was constant, and was much increased in severity by any sudden movement of the body. For the past two weeks had been unable to move about. Up to the time she first complained of these pains had always been rugged and well. Was unaware that she had ever received any injury to the spine. (I afterwards discovered that early in the spring she had fallen on the ice, and, as her mother thought, "sprained her back.") Pressure upon the nates and shoulders caused her to cry out with pain, while extension of the spine, by means of the hands placed in the axillæ, gave instant relief. Crowding the ribs against the bodies of the 10th, 11th and 12th dorsal vertebrae also increased the pain. The case being clearly one of commencing caries, or Pott's disease of the spine, I constructed a rude suspending apparatus, and the next day put her in a plaster-of-paris jacket, after the manner of Dr. Lewis A. Sayre of New York. After a two hours wait, I found the plaster "set," my little patient free from all pain, able to run about, and apparently as well as ever. At the end of four and a half months I removed the jacket. All traces of the disease were gone, and she was permitted to run about as formerly. From the moment she was suspended until the present there has never been the slightest return of the pain.

Case II.—On March 1st, 1883, a gentleman called at my office and asked me to prescribe for his daughter, L. F., aged 15. He stated that she had been generally unwell for some time, that she didn't want to move about, and that she complained of pain in the upper part of the abdomen. He thought she had dyspepsia. I prescribed a simple tonic. Three or four days afterwards, happening to meet her father, I enquired how she was. He told me that instead of improving she seemed to be getting worse, and asked me to go and see her. I did so. I found her in bed, face pale and expressive of suffering, pulse not much disturbed, breathing rather shallow and catchy, tongue slightly furred,

slight cough, without expectoration, no appetite. I asked her to get up and stand on the floor a minute. She slid out of bed very carefully indeed. I at once suspected that something was wrong with the back. I dropped my pencil on the floor and asked her to pick it up. Instead of bending forward as you or I would, she got down by flexing the hip, knee and ankle-joints, and, keeping the spine perfectly rigid and erect, reached out, picked up the pencil, and carefully and slowly assumed the erect posture, taking about as long to pick up the pencil as it has taken me to tell you of it. I then placed my hand on her head and suddenly applied pressure. She flinched, and at once complained of severe pain in the epigastric and dorsal regions. Extension of the spine gave instant relief. Upon examination, I found the bodies of the 7th, 8th, 9th and 10th dorsal vertebrae very sensitive to pressure. The spinous process of the 8th was already quite prominent, and there could be no doubt about the diagnosis. She didn't remember that she had ever fallen or received any injury to the spine, but two or three weeks afterwards her mother recalled to mind the fact that some time in December, while at school, she had had her chair pulled from under her by a classmate, and had remained home two or three days in consequence. On March 10th I put her in a plaster jacket. The plaster set nicely, and I left her perfectly free from pain. The next morning I met her out driving with her father (the first time she had been out of doors in nearly a month), and from that time she made a good recovery of health and spirits. On June 10th, just three months after its application, I removed the jacket for examination. The back was perfectly straight, except that the spinous process of the 8th dorsal vertebra was slightly, and very slightly, prominent. No pain on pressure anywhere. Decided not to reapply jacket for a time at least, and ordered cold bathing and smart friction. There has been no return of the pain.

CASE III.—In October, 1879, was called to see M. H., aged 16. While playing ball he had fallen and sustained a simple fracture of the right femur, middle third. At the time of the accident this right femur was about five inches shorter than the left in consequence of an injury received when an infant. As

I saw the boy immediately after the accident had occurred, I decided to apply the plaster dressing. This I did, taking care to limit the supply of blood to the limb by making pressure upon the femoral artery in Scarpa's triangle by means of a pad of cotton under the bandage. The bandage extended from the condyles to the great trochanter and perineum. After the plaster had become firmly set, the patient was put to bed and kept there a week. He was then allowed to move about on crutches. At the end of six weeks the bandage was removed. Good bony union had taken place, and the patient was discharged from treatment.

It was my fortune to have under my care at one time, early last spring, three gentlemen, all suffering with sprained ankles. Two of these ankles I put in plaster-of-paris, immediately relieving all pain and permitting their respective possessors to pursue their usual avocations. To the other I ordered hot bathing and rest. The bathed and rested ankle confined its owner to the house for two weeks, and after six weeks was still a little lame.

Now for our questions—When, why and how shall I use this immoveable dressing?—questions which I think every intelligent man will want answered before using this or any other remedy, be it new or old. And the "why" follows the "when" so closely, and is so intimately associated with it in all knowledge-seeking minds, that it is almost impossible to consider it separately, especially in the short time now at my disposal. So to save time, and express the "maximum of thought in the minimum of words," we will let this "why" and "when" keep company and so consider them.

It will be seen that all these six cases were the result of violence, either direct or indirect, and, further, that they were the result of violence to joints or bones. It will also be noted that this violence was of such degree, that, baulked by the constant work and strain to which the damaged parts were subjected, nature alone would either fail or be long in effecting anything like a cure, and as it is plainly our business—our duty, if you prefer it—as honest medical and surgical practitioners, to be able and ready intelligently to assist nature in just such a strait

as this, it behooves us to ask what will this remedy do towards assisting nature out of her difficulty.

If properly applied, it will, in the class of cases we have been considering, absolutely prevent motion, it will separate and keep apart damaged or diseased surfaces, and it will bear the weight and strain that would otherwise be forced on a part unable to bear it; or, in other words, it will place the diseased or damaged joint or bone in a condition of perfect rest, which is, as we all know, the condition in which repair takes place most rapidly. Now it will be seen that whenever a case of caries of the vertebræ, fracture of a long bone, dislocation or sprain presents itself, and it is evident that the one indication for treatment is to aid nature by placing the affected part absolutely at rest, the plaster-of-paris dressing fills the bill.

But it may be asked, why use plaster-of-paris in preference to any of the other so-called immoveable dressings? Well, it is more quickly prepared and applied than starch, silicate of sodium, flour and eggs, or any other bandage of that class; it fits the part to which it is applied perfectly, and in this respect is superior to any wooden or leather splint that can be made; it is always at hand, cheap, cannot be pulled off in a moment by a crotchety patient, does not shift its position, and wears. Possessing, as it does, all these virtues, is it at all surprising that the question is asked, "How shall I use it?" I think not, Mr. President. But as I see my paper is already spinning to considerable length, I will be as brief as possible.

To prepare a plaster bandage, procure ordinary cross-bar muslin and freshly-ground plaster-of-paris. Tear your muslin into strips of the desired width; put into these strips with your hand sufficient dry plaster-of-paris to fill the muslin, and roll as any other bandage. Just before using, stand the bandages on end in a dish containing enough water to cover them. Now, while the air bubbles are rising, let us see that our patient is all ready. The part to which the bandage is to be applied should be covered with some tight-fitting garment perfectly free from seams and wrinkles. If it be a case of Pott's disease, and it is of this especially that I wish to speak, you will place over the

abdomen, under the tight-fitting shirt, a folded towel (which is afterward to be removed), to allow the patient breathing space, and make room for his dinner, and then, to extend the spine, sling the patient by means of bands under the arms, occiput and chin. (For a description of a good slinging apparatus, see Sayre's Orthopœdic Surgery, p. 376.) When the air has ceased issuing from the bandages they are ready for use, and you should proceed to apply them as you would any other bandage, taking care to make a good, smooth fit, and to distribute your pressure evenly. The quantity of bandage to be used will, of course, depend on the weight of your patient; only, be sure you apply sufficient to withstand the strain to be put upon it, otherwise your work will be in vain. While applying the bandage, it is well to stop two or three times to moisten the bandage you have already applied, and to rub into it a little dry plaster. This, of course, adds strength. When your bandage is applied, carefully remove your patient from the sling to a bed, rub the bandage well down over the iliac crests, remove the towel, and see that your patient does not move until the plaster is set.

To put up a fracture of a long bone in plaster, it is only necessary to have the bone properly set, and, held by an assistant, to apply your bandage as you would any other. Unless the fracture be near the ends of the bone, it is not, as a rule, advisable to apply the plaster over a joint. In the case of a compound fracture, it will, of course, be necessary to cut a fenestra in the bandage over the wound.

Undoubtedly, the best treatment for sprains, more particularly of the ankle, is, after having bathed the joint well in hot water, to encase it in a strong plaster jacket. This at once relieves the pain, and allows the patient to go about, with only the inconvenience of a stiff joint.

Before bringing my paper to an end, it may not be unseemly in me to offer a word of advice. If you are called to a patient suffering with difficulty of deglutition, cough, pain in the chest or abdomen, flatulence, or dyspepsia, that, on a direct examination of the part complained of, cannot be accounted for, do not fail to make a thorough examination of the spine. Many such

cases, I am sorry to say, are doctored and dosed for dyspepsia, intercostal neuralgia, and the like, that are, in reality, cases of Pott's disease; and this is not discovered until deformity has taken place, the patient become a cripple, and the grand opportunity for successful treatment gone.

REPORT OF CASES.

By JNO. Z. CURRIE, M.D., Fredericton, Registrar Council Physicians and Surgeons, N.B.

(*Read before the New Brunswick Medical Society, July* 18, 1883.)

1.—*Lupus non-Exedens.*—M. L., aged 15, came to consult me February 28th, 1883. The family history revealed nothing of importance, excepting that one brother had a sore upon his neck, which was evidently strumous in character. General health of patient had always been good; catamenial discharge had been established about two years. Nine years ago a small pimple appeared on the right side of the face, near the angle of the mouth, became red in color, and was soon succeeded by others in the same situation. Subsequently other spots appeared upon the upper lip, about the left ear, at three different points upon the back, and upon the left hip. These spots have all remained since their first appearance, and have been constantly, but slowly, increasing in size up to the present time, notwithstanding the fact that she has been under treatment at various times for a period amounting in all to eighteen months.

At the time I first saw her there was nothing marked in her appearance, excepting the red patches before referred to. They were similar in appearance, excepting the one upon the left side of the face. They were all more or less circular in form, of a dull red color, elevated, and somewhat gelatinous-looking. The edges were of a more pronounced red color than the centres. In two of the patches the central spaces were smooth, whitish, and of a parchment-like appearance. They were unattended by pain, itching, or discharge of any kind, occasioned no actual inconvenience, but rendered the person's appearance very repulsive. The patch upon the left side of the face differed in some respects from the others. It was oval in form, about one inch and a half

in length and half an inch in width. The whole patch had a shining aspect, was chiefly without elevation, the skin looked dry and shrunken, and the tubercular masses were separate instead of being aggregated. This patch is, in my opinion, *Lupus Erythematodes*, as described by English writers. The patch upon the upper lip covered the whole lip. Here the tubercular masses studded the edges, and were closely aggregated together; small, thin scales covered the tubercles, and small vessels were seen to run over and through them. The patch upon the left side of the face had invaded the whole external ear and the surrounding parts to a distance of about half an inch all around the ear. The edge of this patch was elevated in the same way as the patch upon the lip, and the ear was very much shrunken and shrivelled, the skin over it rough, and the whole ear considerably drawn by cicatrices. Two of the patches upon the back were about the size of the palm of the hand, the other about one-half as large, and the one on the lip about twice as large. They were all oval in form, and similar in appearance to those already described.

Without delaying to indicate the different steps in a differential diagnosis, in view of the history and appearances, I think I am justified in asserting that this is a case of "Lupus non-Exedens," and that the diseased patch upon the right side of the face, and described as differing in some respects from the others, may more properly be denominated "Lupus Erythematodes." The difference in the appearances presented by two of the remaining patches may be explained by the fact that this disease spreads from the boundary edge, and that as the tubercular growth spreads at the circumference, the central spaces undergo resolution, and the skin then assumes a parchment-like aspect. The treatment pursued in this case was as follows: At first, soothing applications locally—lotions composed of the Carbonate of Zinc, Borax, and dilute Hydrocyanic Acid. Later, a lotion composed of 50 per cent. of dilute Sulphurous Acid was used with apparent benefit; and afterward the destruction of the lupoid growth by caustics was resorted to. These were applied directly to the tubercular masses in such a way as to

avoid both the healthy skin on the outside of the diseased patches and the parchment-like skin, which had undergone resolution, at the centre. The general treatment consisted of the use of iron, cod liver oil, and Donovan's solution. This treatment has been pursued about twelve weeks, and the appearance of the patient is much improved. The diseased patches, although still red, are smooth; the central spaces are clear, and in many places almost normal in appearance.

This case was of peculiar interest to me, inasmuch as I had never seen Lupus Erythematodes and Lupus non-Exedens co-existing in the same individual, although this combination is spoken of as of not very rare occurrence.

2.—*Nævus of the Face treated by Electrolysis.*—H. L., female, aged 8 months, had a prominent nævus on the side of the bridge of the nose. It extended to the internal angle of the eye, upon the lower lid, for a distance of about one-third of the entire length of the lid, and down upon the face about three-quarters of an inch. It was irregular in outline, one arm extending farther down upon the cheek, and the other upon the side of the nose. A small, red point had appeared in this situation a few weeks after birth, and had constantly enlarged both in outline and in prominence. This was evidently a nævus, in which the skin, subcutaneous cellular tissue, arteries, veins and lymphatics were involved. About four weeks before this case came under my observation, an effort had been made to remove the mass by means of strong caustics. The result was great swelling of that side of the face and eyelids, accompanied by considerable pain and constitutional disturbance, and, later, greater deformity and an increase in the size of the nævoid growth. Although a nævus is frequently of very little importance, yet, when seated upon the face, and especially in the case of females, its removal in such a way as to leave as little deformity as possible becomes a matter of the greatest importance. In this case the deformity was very considerable, and rapidly becoming more so, hence the necessity for immediate interference. The question, then, to be determined was—By what means this deformity could be most effectually removed with

the least danger to the patient and leave the least evidence of having existed? Tying would have been difficult to accomplish, and not likely to have been attended with good results; the actual cautery would have accomplished too much, probably producing ectropion, as the growth was evidently spreading between the skin and tarsal cartilages, while there was already evidence of the effect of caustics upon it, and injections are generally unsatisfactory. All treatment except that of partial destruction seemed inadvisable. It was hoped that by electrolysis, centres of slough might be produced through the whole thickness, and from these coagulation and contraction would spread throughout the entire growth in the manner described by H. H. Hutton of St. Thomas's Hospital. Hoping to avoid an external slough, a battery composed of but six cells was used. The first application was made on March 20th, 1883. The result of this application was very satisfactory. There was no homorrhage, the needles leaving behind tunnels of destroyed tissue. No local irritation of importance nor constitutional disturbance followed. After a few days a very sensible improvement was apparent. The irregularities of the mass were obliterated, and the whole mass diminished in size. Very soon the centre of the tumor began to distend again, when the child cried, and a second application was made on the 6th of April. At this time more was accomplished than was intended. Considerable tumefaction resulted, followed by an external slough at the edge of the mass. The swelling, however, after one or two weeks, became reduced, and the nævus was found to be still further reduced in size. Two subsequent applications effected its complete removal. Considerable redness of the part remained for some time, but is fast disappearing, and the skin is assuming its natural appearance.

The principal objection to this treatment is the liability to recurrence after apparent removal, frequently rendering a repetition of the treatment necessary. In this case, although the result was not obtained wholly in the way anticipated, an external slough having followed the second application, yet the result is, upon the whole, satisfactory. In my opinion, this mode of treatment has accomplished more, with less discomfort to the

patient, and has left less deformity than could legitimately have been expected from any other course of procedure.

QUARTERLY RETROSPECT OF SURGERY.

PREPARED BY FRANCIS J. SHEPHERD, M.D., C.M., M.R.C.S., ENG.
Surgeon to the Montreal General Hospital; Professor of Anatomy and Lecturer on Operative and Minor Surgery, McGill University.

Suture of Nerves after Division.—All surgeons are agreed as to the propriety of uniting by suture the ends of nerves seen divided in recent wounds, but the suture of divided nerves long after the original wound has healed has not yet been extensively practised. Many cases of successful suture of divided nerves have lately been reported in the various medical journals. Mr. T. Holmes (*Lancet*, June 16, 1883) reports a case of suture of the musculo-spiral nerve five months after its division. The scar of the wound which severed the nerve was on the outer side of the back of the right elbow. Sensation was completely lost in right hand and forearm for a week after the accident, but partly returned after this time. On admission to hospital, the patient could pronate and supinate his forearm, with the elbow flexed, but could not extend the fingers or wrist in the slightest degree, and supination was impossible in the extended position of the forearm. The limb was much wasted. No pain was suffered, but there was a tender spot at the extreme end of the scar, just external to the biceps tendon. Operation was determined upon, and on cutting down, the two ends of the nerve were found without much difficulty. The upper end of the nerve seemed to have retracted, and terminated in a bulb the size of a common pea; the other end was somewhat atrophied. The two ends were more than an inch apart; a little of the lower end of nerve was taken off to freshen it, and part of the bulb on the upper end removed. The ends were easily approximated and kept in position by catgut and fine silk sutures. The operation was performed antiseptically, and the wound united by first intention. The operation was performed on March 10th, 1881; by March 15th there was some slight power of extension returning, and a few days later sensation on the back of the hand

was more perfect. The patient then left the hospital, and was not heard of for two years, when he returned to show how completely he had recovered,—sensation was perfect, and there was no difference in the size of the two arms. The patient said that it was about a year before improvement was very obvious to him, then he began to mend rapidly. Mr. Holmes remarks that to Mr. Wheelhouse we are indebted for having brought this operation prominently before the profession; his great success in uniting a sciatic nerve nine months after its division encouraged surgeons to adopt the operation. The uniting of divided nerves in recent wounds has been largely practised, and with much success, but as in these cases the wound very frequently recovers its function without this procedure, it is impossible to say whether the same result would not have followed had no suture been used; but Mr. Holmes asks: "Is the case of old injury and persistent loss of function really different? Will the nerves in these cases recover their functions if left to themselves?" That they do in some cases Mr. Holmes thinks is certain, and gives cases to prove it, but, he remarks, such a favorable issue is highly dubious, especially, as in his own case, where the interval between the divided ends is large and the nervous filaments are included in a large bulb. In such a case, any restoration of its anatomical continuity appears hopeless. Statistics as to the results of secondary suture are not of much value, because many cases are reported too soon after the operation, many cases not being greatly benefited till some time has elapsed after the operation, as in Mr. Holmes' case. Tillmanns records 13 cases of secondary suture; of these, Mr. Holmes classes 8 as successful, 3 as dubious, and 2 as failures. Mr. Bowlby, in his Jacksonian prize essay on the *Injuries of Nerves*, records 20 cases, 6 only of which were perfectly successful. With regard to the time after the injury at which the operation should be undertaken, Mr. Holmes says we are not yet in a position to lay down certain rules. If the parts are quiet, and the wound completely healed, there can be no motive in deferring the operation. However, Mr. Jessop operated on the ulnar nerve with partial success nine years after its division. Mr.

Holmes lately united the median and ulnar nerves eight days after the accident, and thought it would have been better to have waited till all inflammation in the wound had passed over, or even till the wound had entirely united. Mr. Holmes thinks that in suturing the ends of the divided nerve it matters little whether the suture be passed through the thickness of nerve or not, as long as the sutures have a firm hold. He uses catgut ligatures, reinforced with one or two of fine silk or horse hair. No instance has yet been recorded of any harm from the operation—no tetanus or acute neuritis.

Mr. Herbert W. Page (*Brit. Med. Jour.*, June 23rd, 1883) records a case of secondary suture of the ulnar nerve six months after its division. The nerve was divided near the wrist; after the wound healed, the cicatrix was very painful, and the little and ring fingers became bent and useless, so that patient had to carry his hand in a sling. His general health became seriously affected by the constant pain in the wound and its neighborhood. Sensation was very defective, though not entirely absent. At the patient's request, operation was decided upon, and the separated ends of the nerves found with much difficulty. The upper end of the lower portion was imbedded in thick cicatricial tissue, but was not enlarged; the lower end of the upper portion was swollen to about three times its natural size, and ended in a firm bulbous nodule, which was bound in cicatricial tissue. It was necessary to dissect the upper part of the nerve free for about two inches before the two ends could be brought together. They were joined by three fine catgut sutures passed through both sheath and nerve. The wound healed by first intention, and when he left the hospital, some three weeks after the operation, sensation had decidedly improved, the cicatrix was free from pain, and he had some returning power of extension of the last phalanges of little and ring fingers. In a fortnight after patient had made little progress, so he was placed under the care of Mr. De Watteville for treatment by electricity. Electricity was continued for a year by Mr. De Watteville, and having regained fair use of his hand, he ceased to attend the hospital, but applied the faradic current himself for six months. When last seen he

had been at work for several months, and his hand was as useful as ever. Mr. Page attributes his patient's recovery to the steady and long-continued use of electricity to restore the nutrition of the wasted muscles; but might not the same result have been accomplished without it, as in Mr. Holmes' case.

In another similar case, however, of Mr. Page's, operated on at the same time, the result was not so fortunate, because the patient, being a nervous, hysterical woman, persisted in keeping her hand in a sling, and refused to have electricity applied.

Treatment of Nævi.—Mr. Martin Coates, at the recent meeting in Liverpool of the British Medical Association, read a paper on the *Treatment of Nævi* (*Brit. Med. Jour.*, Aug. 18th, 1883). He began by stating that for superficial venous nævi he adopted the late Dr. Marshall Hall's method with complete success. His object was to excite just so much increased action in the growth as to cause deposition of lymph and occlusion of its vessels. A cataract needle was introduced about a line from the circumference of the nævus, and passed from the point of its entrance to the opposite extreme edge of the growth, keeping it, in all its course, as near as possible to the surface. The needle was then withdrawn almost to its point of entrance, and pushed again through the nævus at about one-sixteenth of an inch from the line of the first puncture, and so on until the lines of the puncture took a fan shape. It is desirable to keep the needle as close as possible to the surface, though, should it penetrate the thin covering of the growth, a piece of adhesive plaster arrests the bleeding immediately. A small white spot soon makes its appearance in the centre of the growth; this gradually spreads and there is left in a few months a spot perfectly smooth, and whiter than the surrounding skin. One operation has invariably succeeded with Mr. Coates in superficial venous nævi.

The *bright scarlet or arterial nævus*, whether it appears as a small bright spot, or as a patch measuring two inches in diameter, or, again, as one or two minute arterial branches, requires, remarks Mr. Coates, a more pronounced treatment, based, however, on the same principle—stimulation, not destruction of tissue. In his first case, the author punctured the nævus with

a bleeding lancet, and into the puncture passed a small point of nitrate of silver, holding it there a few moments. The nævus was cured, and no scar was left. Since then he has used a large needle with a blunt flat end. This he introduces with the flat end at right angles to the skin, and tears through each vessel. Ecchymosis takes place, which is soon absorbed, and the nævus is cured.

When the nævus, venous or arterial, exceeds a thickness of one-sixteenth of an inch, the needle operation is not applicable. In these cases, Mr. Coates injects undiluted tincture of iodine. The operation is very simple. Wood's syringe, with a very small needle, is all that is required. Sufficient tincture of iodine to fill the nævus having been drawn into the syringe, the needle is introduced through the skin at about a line from the circumference of the nævus, and passed to its centre; the piston is propelled slowly home, so as to force the tincture into every part of the growth. This is facilitated by moving the point of the needle into every part of the nævus. The needle is then withdrawn, and pressure made on the puncture for a few seconds, and then the operation is complete. Mr. Coates has practised this treatment many times, with complete success, since 1861. One injection generally succeeds.

At the same meeting, Mr. Edmund Owen also read a paper *On the Treatment of Large Nævi.* The nævi referred to are not of that variety, says Mr. Owen, which may be readily or effectually obliterated by the use of ethylate of sodium or nitric acid; they are vascular tumors, varying in size from a dried raisin to a ripe fig, and which, situated in and beneath the skin or mucous membrane, are steadily growing. After alluding disparagingly to the treatment by ligatures and setons, Mr. Owen goes on to say that in his experience all the demands are supplied and the objections avoided by the treatment of large nævi by that useful instrument, the thermo-cautery of Paquelin. The larger the nævi, the larger the heated point needed. Having heated the point of the cautery to dull redness, the blade is thrust through the skin in as many places as may be considered necessary, and the point directed to all regions of the vascular

additional force is derived from the muscles of the back, the glutæi, and the other extensors of the thighs. (The description is much more easily understood when reference is made to the excellent illustrations accompanying the article.)

The Treatment of Hordeolum.—Mr. Fitzpatrick gives his recent experiences in the treatment of hordeolum (*Lancet*, April, 1883), or the common stye, during the time he was in Egypt. The plan of treatment adopted is to dispense with hot fomentations, &c., and to apply locally tincture of iodine to the lids, care being taken to keep them apart till dry. A few applications in the 24 hours is often sufficient to arrest the development of the stye. (*Practitioner*, Aug., 1883.) I have found that the application of spirits of wine to the lid, when a stye is commencing, often arrests its progress, probably by causing contraction of the blood-vessels, and so driving on the stagnated corpuscles. The alcohol should be applied with a camel's hair pencil every few minutes for an hour or so. The application is quite pleasant, and will not disfigure, as the iodine application is sure to do.

Anæsthetics.—Deaths occurring during and after the administration of anæsthetics are reported from time to time in medical journals. The exact conditions which lead to a fatal result are not well understood, perfectly healthy individuals often rapidly succumbing, whilst others, who are in a very bad general condition, escape. The dose of the anæsthetic seems to have little to do with the fatal result, as many deaths occur at the very commencement of the administration, before more than a few drops have been inhaled. We have yet much to learn about the administration of anæsthetics. So far, I think, without doubt, ether has proved to be the safest, yet chloroform still holds its place from the ease with which it is administered and the rapidity with which it produces anæsthesia. The mode of administration is yet disputed point. Some say to give ether rapidly and safely, keep out air, and, when giving chloroform allow patient to inhale plenty of air; others, again, say that safe administration lies in giving plenty of air with ether and none with chloroform. A valuable paper by Dr. R. Marcus Gunn, in the *British Medical Journal* of July 21st, 1883, on

"Statistics of Anæsthetics in relation to After-sickness and the Death-rate," will assist us in arriving at more correct conclusions on these points. Dr. Gunn, whilst House Surgeon at the Royal Ophthalmic Hospital, Moorfields, administered anæsthetics altogether 4,158 times. In 45 per cent. (1,902) of the cases there was sickness, and from the tables he gives it seems that females had a much greater tendency to sickness than males. The liability to sickness is at its maximum about the commencement of puberty, and decreases gradually towards each end of life. Dr. Gunn considers age the most important factor in relation to after-sickness. Chloroform was used for children under 3 and for adults over 60; between these ages, ether, a mixture of ether and chloroform vapour, or a mixture of absolute alcohol, chloroform and ether (in proportions respectively of one, two and three) was used. The author's impression is that, ages being equal, the tendency to after-sickness is about the same with ether as chloroform. Ether-sickness seldoms lasts long after the stomach is emptied; chloroform-sickness often continues for several hours and leads to great exhaustion. With regard to the influence of food, Dr. Gunn comes to the following conclusions: 1. Too long a fast is a disadvantage, especially in the very young and aged. 2. Speaking generally, the last meal should be given about four hours before the operation.

The weather has an influence on after-sickness; on certain days nearly every case was sick, while on other days sickness was entirely absent. There was less sickness when the wind was easterly. The highest percentage occurred in January; the lowest in March. Only one death occurred, during the administration of a mixture of ether and chloroform. The patient was a stout woman, aged 46. At the necropsy, the heart was found to be fatty. The author thinks, in this case, death was due to shock, as the anæsthetic had only been administered for one minute when the pulse failed and the respirations became shallow. Another case died after removal home. Patient was a fair, delicate-looking girl, aged 8, who recovered from the anæsthetic in the usual way, and spoke to the nurse, but remained pale, and began to be sick an hour after the operation. She was taken

home by her friends, and never spoke after leaving hospital, but died that evening. I should certainly attribute the death to the anæsthetic, because, if it had not been administered, the girl no doubt would not have died; but the author is doubtful about the case, as no autopsy was held.

Ether was introduced into Moorfields about the beginning of 1874, and from that date up to the present time anæsthetics had been administered 13,000 times, with only one death (the case of the woman described above) that can be fairly attributed to the anæsthetics. Dr. Gunn says that, next to carelessness, nothing is more calculated to increase the death-rate than widespread dread of its dangers. Mr. Roger Williams gives the death-rate as 1 in 350 inhalations. This the author thinks very exceptional, and he does not believe the majority of fatal cases are hushed up. Alarming symptoms will, he says, unavoidably occur occasionally during anæsthesia; but the greater the proportion of such cases to the actual number of deaths, the smaller the *real* danger. The anæsthetic must not be blamed for all cases of death. Chloroform vapour, without the admixture of air, will paralyze a strong heart, not to mention a fatty one; the shock of a severe operation will kill without an anæsthetic. A moribund patient may die of mere shock of removal to the theatre and dread of the operation, nor is the risk removed till perfect anæsthesia is produced.

Dr. Gunn concludes by stating that he believes Mr. Roger Williams' statistics give a much too high death-rate, as many of his fatal cases were not directly due to the anæsthetic. He believes that a mortality of one (or at least two) in 13,000 cases, as at Moorfields, corresponds more nearly with general experience. He states that his paper has been principally written "to prevent an unwarranted popular dread of anæsthetics—a dread, I am convinced, in itself most dangerous."

Treatment of Warts and Condylomata by Carbolic Acid.—M. Jullien has described, in the *Annales de Dermatologie*, the treatment used by Tommaso de Amicis and himself in cases of warts and condylomata. It consists in repeated cauterizations by means of pure carbolic acid, and is best adapted to large

sessile growths or to fungating cauliflower-like vegetations. The method of application is very simple. Crystals of pure carbolic acid are kept in a small bottle; the warts having been washed, the bottle is warmed in a flame or in nearly boiling water, and the crystals touching the glass melt. The fluid is applied to the whole surface of the warts with a brush or cotton wool. The warts soon assume a shiny, white appearance. The white layer soon falls off, and next day the operation can be repeated. Pure carbolic acid causes much less pain than chromic or acetic acid. The last cauterizations are always more painful than the first. In a case of vegetations on the glans and prepuce, the cure was complete after two applications.—(*Brit. Med. Jour.*, Aug. '83.)

Treatment of Erysipelas of the Face.—Roth has revived Wilkinson's old method of treating erysipelas, and Unna (*Monatsch. f. Prak. Derm.*) reports a case so treated. It consists simply in giving every two hours a tablespoonful of a mixture of eight parts of carbonate of ammonia with 210 parts of any convenient menstruum. Unna's case was very severe, with high fever, sleeplessness, and delirium. In 24 hours the affection was under control and amendment had occurred, and in three days the patient was well. No external applications were employed.—(*Quoted in Jour. Cut. and Ven. Dis.*, Aug., '83.)

Treatment of Floating Kidney by Fixation.—Dr. David Newman of Glasgow performed the above operation for the first time in Great Britain. The method described (*Brit. Med. Journal*, April, 1883) is the usual one, viz., exposing the kidney by a vertical incision in the right loin, just external to outer edge of the quadratus lumborum, and extending from the lowest rib to the crest of the ilium, opening the capsule of the kidney and stitching it to the sides of the wound, and two catgut sutures in this case were passed through the cortex of the kidney. The external wound was closed by button sutures. The patient was entirely relieved, and soon recovered from the effects of the operation. Dr. Weir, of the New York Hospital, has lately (*New York Med. Journal*) reported a successful case.

Ligature of the Innominate Artery for Subclavian Aneurism.—The operation of ligature of the innominate, which was lately

performed by Mr. Wm. Thomson of Dublin, at the time excited great interest and a hope that the case would turn out favorably, but, unfortunately, hemorrhage occurred on the 30th and 39th days, and the patient died on the 42nd. The account of the case given by Mr. Thomson in his pamphlet is most interesting. The hemorrhage did not occur from the point of ligature, but from an ulceration in the artery a quarter of an inch away. The coats of the artery were not at all divided by the ligature, and though the ligature had entirely disappeared, the artery was quite occluded at the point of ligature.

Reviews and Notices of Books.

The Essentials of Pathology.—By D. Tod. Gilman, Professor of Physiology in the Starling Medical College, Columbus, Ohio. 296 pages and 47 cuts. Philadelphia: P. Blakiston, Son & Co. 1883.

This is an excellent little work, which quite fulfils the objects of the author, viz., "to unfold to the beginner the fundamentals of pathology in a plain, practical way." It is well up to date, and the main essentials of pathology are detailed in a clear and instructive manner. The woodcuts are old friends, as a rule good, but not numerous enough. Though not in any way equal to Green's Manual, it will prove a very useful work to any student or practitioner who may wish to get a *resumé* of recent pathology.

A History of Tuberculosis.—By Eric E. Sattler, M.D. Robert Clarke & Co., Cincinnati. 1883.

The publishers, for the sake of the reputation of their house, should have made Dr. Sattler alter the title of this work to "Spina on Tuberculosis," translated, with additions, &c., by E. E. S. This would have been honest; but it is not right for any one to take another man's work, translate it and make some additions, and then issue a volume, as this one has been issued, with *Taberculosis, Sattler*, on the cover. True, on the title page it is stated that the work is in the main a translation of Spina's

recent *brochure*, but this was not enough, and when we casually picked up the book we recognized *Spina* in the text before we had noticed his name on the title page. We have already referred to Spina's position in the tubercle-bacillus dispute. This work contains an admirable history of the tubercle doctrine and a full account of Koch's investigations, as well as those of subsequent observers, and is the most extensive monograph on the subject which has been published. We welcome it in English dress, and commend it to our readers.

A New School Physiology.—By RICHARD J. DUNGLISON, A.M., M.D. 314 pages and 117 engravings. Philadelphia: Porter and Coates.

The best popular physiology with which we are acquainted, admirably illustrated, and in every way adapted for school use. We should like to hear of this work as a text-book in every High School throughout the country.

Books and Pamphlets Received.

ANATOMY, DESCRIPTIVE AND SURGICAL. By Henry Gray, F.R.S. With an introduction on General Anatomy and Development by T. Holmes, M.A., Cantab. The drawings by H. V. Carter, M.D., with additional drawings in later editions. Edited by T. Pickering Pick. A new American from the tenth English edition, to which is added "Landmarks, Medical and Surgical," by Luther Holden, F.R.C.S., with additions by William W. Keen, M.D. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Bros.

THE INTERNATIONAL ENCYCLOPÆDIA OF SURGERY. A Systematic Treatise on the Theory and Practice of Surgery By authors of various nations. Edited by John Ashurst, Jr., M.D. Illustrated with chromo-lithographs and woodcuts. In six volumes. Vol. III. New York: Wm. Wood & Co.

TRANSACTIONS OF THE MEDICAL SOCIETY OF THE STATE OF PENNSYLVANIA at its Thirty-fourth Annual Session. Vol. XV. Published by the Society.

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Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, June 14th, 1883.

R. A., KENNEDY, M.D., PRESIDENT, IN THE CHAIR.

Hodgkin's Disease.—Dr. Osler exhibited this patient, a farmer, large and well-built, 24 years of age, with good family history.

Enlargement of glands began 18 months ago. The cervical and axillary very large; inguinal slightly enlarged, but not the thoracic nor abdominal. Not markedly cachectic, but looks much older than 24 years. Says he is much darker than before disease began. Not specially anæmic. There is one-fifth of a reduction of red blood corpuscles, one colorless to 150 red. Left arm is œdematous from pressure of mass in axilla. One gland over left clavicle necrosed. Has continuous pyrexia, very little pain, slight cough. Has had an itchy papular eruption for past year. This known to be sometimes present in this disease, Dr. Osler said it was a typical case, and was the third he had seen this spring. Is giving him arsenic; has seen glands lessen with this remedy in two cases.

Dr. Osler shewed specimens of *Hydatids* under the microscope. They were from a patient of Dr. MacLaren's, of Paisley, who had been passing them for some time in his urine. Dr. Osler had tabulated sixty-three cases, in none of which were they found in the kidney. It is possible these may have come from Peritoneum and into bladder.

Dr. Osler showed a *Lympho-sarcomatous growth of Bronchial Glands* in a patient under Dr. Wilkins's care. It involved portions of both lungs and pleuræ. Secondary growths were also found in pancreas and on membranes of spinal cord. The latter was the cause of death, its rapid growth and pressure on cord producing acute myelitis.

Dr. Wilkins stated that patient had been brought into hospital about eight or ten days previous to his death, in a completely paraplegic state; he had been so for ten days. For about five or six weeks previous to the setting in of the paraplegia, he had been complaining of "rheumatic" pains in his shoulders, and also in his legs, but had been quite well up to that time. The paraplegia with bladder trouble set in within twenty-four hours of his first noticing any loss of power in limbs. On entering hospital there was complete anæsthesia and paraplegia extending up to level of sixth costal cartilage. He had typical bullæ on internal surfaces of both knees where they had been in contact, on buttocks and on one external

malleolus, points to early irritative lesion of posterior roots on cornua. Muscles responded to a strong faradic current when he entered hospital; but this faradic excitability had quite disappeared the day previous to death. The only objective symptom pointing to a lung lesion, was the presence of bronchial râles.

Dr. Osler exhibited a *large Amyloid Liver* from a patient who died of phthisis under Dr. Wilkins care.

DR. WILKINS stated that the case had been one of several years standing, during all of which time patient had more or less profuse expectoration; lower margin of liver extended to crest of ilium, and about one inch below umbilicus. No unusual symtom was associated with the case, until about a fortnight previous to his death, when jaundice made its appearance, the color gradually becoming very deep. Dr. Wilkins had considered the occurrence of jaundice with amyloid liver as of very rare occurrence, and in this case had supposed it to be due to the pressure of enlarged lymphatics on bile ducts, the cause usually assigned for this condition. At *post mortem* glands were found to be only slightly enlarged, and ducts pervious, and as he had not yet made a microscopical examination, he could not give any positive reasons for the jaundice.

Dr. Wilkins exhibited a number of microscopical sections made from different regions of spinal cord of a patient who died of myelitis, in which the microscopic as well as the physical signs shewed the posterior cornua to have been less affected than the anterior. There had been complete loss of power of both legs, with paresis of muscles of arms, hyperæsthesia; a bed sore making its appearance only after the sixth week of illness. Under the microscope, some of the motor ganglion cells could be seen swollen to more than twice the normal size; others with one or more large vacuoles, which gave the appearance of the ganglion being filled with fat cells, but their reaction with prussic acid shewed they were not fat; other motor ganglion cells existed only in a shrunken condition, some with these processes quite disappeared. In all the sections leucocytes could be plainly seen scattered through the field. The sections

were all double stained—some with sulph-indigotate of soda and carmine ; others with picro-carmine and logwood.

Uterine Fibroid.—Dr. Gardner exhibited fragments of a uterine fibroid removed by him assisted by Dr. Ross, whose patient she was. Patient had been blanched with hæmorrhages ; on examination uterus was found enlarged. Dilatation by means of tents revealed a sub-mucous fibroid, size of an egg. Repeated applications of strong solution of iodine did not stop the hæmorrhages. Again dilated and separated the tumor by Thomas' scoop and a pair of scissors. The operation was very difficult as the tumour was sessile. Iodoform was used as a dressing, it kept everything sweet. No hæmorrhage since removal, now three weeks.

Dr. Ross said that fourteen months ago she began to have excessive flowing, gradually grew worse, lost much each month. After a time an examination was allowed, when he found the above condition to be present. It took two and a half hours to remove the tumor. Her condition in spite of having a small growth, size of a marble in right cornua, is very satisfactory.

Dr. Alloway asked if Dr. Gardner ever used Emmet's traction operation for uterine fibroids, which in time produced a pedicle.

Dr. Gardner believed Emmet's operations to be very good ; but not suitable for this case as the base of the tumor was so large, being something like a hump on the uterine wall.

Tracheotomy.—Dr. Alloway read a paper embodying the history of 6 cases of tracheotomy in children, 4 of which ended in recovery. The ages ranged from 2 to 7 years. Three were males and three females. Of the recoveries two were females and two males ; of deaths, one male and one female. The ages of those which recovered were two, three, three and seven years, respectively. In two there were diphtheritic patches recognized in the throat ; the remaining four were membraneous croup. Of recoveries, two were subject of diphtheria and two membraneous croup. In the successful cases the tube was removed on the seventh, eleventh, thirteenth and fourteenth day. Steam and carbolized dressing were used in all ; the steam was not

generated directly in the room, but obtained from boiling water kept constantly supplied to large flat tin vessels on the floor of the room. The operation in all was performed early.

Dr. Bell said he had recently performed tracheotomy four times for diphtheria. All were bad cases in young children, and had to be done in a hurry, as children were cyanosed. First case, 3 years old; opened below thyroid; lived about forty-eight hours; membrane went below wound; no *post mortem*. Second case, 3¼ years; within forty-eight hours the wound was covered with membrane. Applied glycerine and carbolic acid; died fourth day; *post mortem* shewed membrane in small bronchii. Third case was brother to last, no membrane seen, but great relief followed opening trachea; took nourishment well for thirty-six hours; tough secretion now formed, and forty-eight hours after operation was almost suffocated by it; was relieved by passing feathers down and removing secretion, this gave great comfort, and had to be repeated frequently; died after four days; *post mortem*; no membrane in trachea, but died of lobular pneumonia from pushing down dry secretion with feather; temperature ran high. Fourth case; membrane in trachea was relieved by operation, but gradually sank; died from infection seventeen hours after operation. Did not steam with any of these cases.

Dr. Bell read following extracts from a paper on this subject by Dr. H. Linder:—

Out of 106 cases of tracheotomy for croup and diphtheria 63 died and 38 recovered. Of 79 cases in which obstruction of air passages was the prominent morbid condition, 44 died. The chances are slight under two years. Operate when retraction of chest becomes a prominent sign. Superior operation done in all but 5 cases. Prefers it on account of thymus gland in young children. He recommends chloroform in all cases except where intense asphyxia. When the signs of great general infection were marked, that is in 22 cases, all died. Uses steam, thinks it useful in lessening the dry and firm secretion at end of tube; but thinks it produces pneumonia sometimes, and increases danger in that way. Recommends

apomorphia in large doses. It increases watery secretion from bronchi and separation of membrane. Next to general infection thinks that pnemonia is chief difficulty and is indicated by sudden rise of temperature.

DR. BLACKADER said he believed steam to be very useful in these cases. Lately he had seen its good effects in a patient of his suffering from laryngeal diphtheria on whom Dr. Roddick had operated. One day the steam (which was directed under a tent over the bed) was discontinued by the attendant, when the child became alarmingly worse, but after being renewed she breathed easier and ended in complete recovery, although was paralyzed for a time.

DR. FENWICK advocated use of steam. Although last year had two cases of tracheotomy for diphtheria where, owing to lack of accommodation, steam could not be used and yet both recovered.

DR. RODDICK had performed the operation thirty odd times. He said his rules were: 1st. To dissuade from operating if glands engaged, for the patients are almost sure to die of septicæmia, and the operation hastens the fatal issue. 2nd. Has given up the idea of operating with a single assistant; must have two, one to give anæsthetic and one to assist the operator. Believes ether better than chloroform. Never saw ether act badly. Made a rule now of doing the low operation, raising the thyroid is easy and simple, the lower part of isthmus being loose on the trachea. Uses no haste in putting in tube, has known the tube to be put to one side and be the cause of death. Believed Trousseau's old double tube with or without moveable shield to be the best; always uses steam, thought it very necessary.

Drs. Alloway, Roddick and Bell had all seen cases where there was much difficulty in permanently removing the tube, owing to suffocating symptoms coming on, due to spasm and also exuberant granulations in the trachea, which stand out and lessen calibre when the pressure of the tube is removed.

DR. MAJOR considered that a record of tracheotomies to be of any statistical value, required to be divided as to the condition for the relief which the operations were undertaken. In

his experience opening the air passage in diphtheria has proved eminently unsatisfactory—*in so far as life-saving power was concerned*—whereas for the relief of other conditions it had been universally successful—in any case the more early the tracheotomy the better. He would also call attention to the neglect of laryngoscopic examinations. He thought, when none was had, that both patient and practitioner were at a great disadvantage; as at least we might determine the character of the obstruction; whether œdema, membrane, (diphtheritic or croupous) or as he had even seen papillomatous growths mistaken for croup, and an operation so long delayed that a fatal termination from congestion of the lungs was the result. And we should also know whether the membrane extended below the point of our proposed incision, a matter of some moment in deciding upon operative procedure.

CANADA MEDICAL ASSOCIATION.

Opening of the Session, Sept. 5th.

At 10.20 o'clock Dr. Mullin, of Hamilton, the newly elected President, was introduced to the Association. He thanked the Association for the honor they had done him, and hoped the meeting would be highly successful.

Dr. Sullivan intimated that the local committee had made all necessary arrangements.

Mayor Livingston and Dr. Sullivan then, in humourous and eloquent speeches, welcomed the Association.

Dr. Williamson, on behalf of the Queen's University, also addressed the Association.

A number of Past Presidents and Vice-Presidents were asked to take seats on the platform.

Dr. Mullin thanked the speakers for the hearty reception accorded to the Association. He felt that their visit to Kingston would be much appreciated. In no place had they been more heartily received.

Dr. E. Robillard, of Montreal, Treasurer, being absent, Dr. Sheard of Toronto was nominated in his place.

The following medical visitors were present: Dr. Hurd,

Pontiac, Mich.; Dr. V. O. Walker, Detroit, delegate from the American Medical Association; Dr. D. McLean, Ann Arbor.

The following members were in attendance: Dr. Mullin, Hamilton, President; Dr. Osler, Montreal, Secretary; Dr. Dupuis, Kingston; Dr. T. M. Fenwick, Kingston; Dr. W. H. Henderson, Kingston; Dr. Canniff, Toronto; Dr. Worthington, Trenton; Dr. Bray, Chatham; Dr. Oliver, Kingston; Dr. Bottsford, St. John; Dr. Sullivan, Kingston; Dr. Sloane, Blythe; Dr. Campbell, Seaforth: Dr. Bingham, Seaforth; Dr. K. N. Fenwick, Kingston; Dr. Reeve, Toronto; Dr. Phelan, Kingston; Dr. Graham, Toronto; Dr. Tye, Chatham; Dr. Proudfoot, Montreal; Dr. Yeomans, Mount Forrest; Dr. Mallock, Hamilton; Dr. Irwin, Kingston; Dr. Sweetland, Ottawa; Mr. Metcalfe, Kingston; Dr. Fenwick, Montreal; Dr. Gardner, Montreal; Dr. LaRocque, Montreal; Dr. Playter, Toronto; Dr. Small, Ottawa; Dr. Oldwright, Toronto; Dr. Saunders, Kingston; Dr. Pickup, Brockville; Dr. Roddick, Montreal; Dr. Dickson, Wolfe Island; Dr. Neilson, Kingston; Drs. J. Bell, J. A. McDonald, W. Hingston, Major and Buller, Montreal; Dr. Tobin, Halifax; Drs. Burnham and Sheard, Toronto; Dr. Dorland, Milwaukee; Dr. Grant, Ottawa; Dr. McCammon, Kingston; and others.

A letter of regret was read from Dr. Brodie, of Detroit, a delegate from the American Medical Association.

Dr. Canniff (Toronto), Chairman of Committee on Sanitary and Vital Statistics, reported that there had been no meeting of the committee; that its place had been usurped by a committee of gentlemen who met at Ottawa during the past winter.

Drs. Playter and LaRoque explained their connection with that meeting.

Dr. LaRocque (Montreal), Chairman, read the report of the Committee on Climatology and Public Health. The report referred at great length to the history of what has already been done in this country. He alluded to the Government grant, and advocated its expenditure in the collection of mortuary statistics. He recommended a central bureau with local boards in all the larger cities and towns for the collection of statistics.

Dr. Yeomans said in Hamilton the physician notifies the teachers of schools of any cases of infectious diseases. This lessens the mortality, while it increases the attendance.

A vote of thanks was passed to Dr. LaRoque for his very complete report.

The following were appointed as Nominating Committee: Drs. Botsford, G. E. Fenwick, Grant, Graham, Rodger, Brady, Worthington, Malloch, Oliver, Tye, Sweetland, Canniff, Oldwright and Yeomans.

The meeting then adjourned for lunch.

General Meeting.

The Association met at 2 p.m., Dr. Tye (Hamilton), Vice-President, in the chair.

The President (Dr. Mullin) returned thanks for the honor conferred upon him. After making a brief allusion to the death of Dr. David of Montreal, late secretary of the Association, whom he described as a man of the strictest integrity, of the highest sense of honor, and an example to young men, he said that each of the medical societies had its sphere of usefulness. The county, city and provincial associations could do work that would advance the interest and knowledge of the members of the profession, but the highest and best results are to be attained by the Association gathering together each year the members of the profession from all parts of the Dominion, who, in the discussions, would reflect the progress they were able to make. He said he would not attempt even a slight sketch of the work of the past year, but would confine himself to one subject: The agencies through which the decomposition of organic substances was effected. After an able and eloquent address on this subject, he said, in conclusion: Our present knowledge is in accordance with what was long since found true, that in contagious fevers and tubercular diseases our efforts must depend to a great extent on our success in teaching the public to rely less upon antidotes and more upon those means which tend to build up strong frames capable of withstanding the agencies causing disease.

Dr. Graham of Toronto was nominated chairman of the Medical Section, and Dr. Tye of Hamilton of the Surgical Section. The meeting then divided into sections.

Medical Section.

The section met at 2.30 p.m., Dr. Graham in the chair.

Dr. Playter (Toronto) read a paper on "*Diet as a Thera-*

peutic Agent." He said that many cases of illness were due to errors of diet, especially to overfeeding and improper mastication. Observation and recorded cases show that health can be maintained on very much less food than is usually consumed. When illness is due to prolonged excess of food, restricted diet, without medicines, always effects a cure. Persons who habitually eat too much are more liable to attacks of acute diseases, to gout and to rheumatism. Heart disease and tuberculous disease are also caused by excessive feeding. In debilitating diseases, give concentrated and peptonized foods, with iron and phosphates. In functional heart disease, enquire into the diet. He then reported the case of a female, aged 46, unmarried; good family history; always healthy till ten years ago, when she began to suffer from dyspnœa, which has been steadily increasing. When seen, there was urgent dyspnœa, weak pulse, flatulence; color good, no pain, the bowels regular; no sign of valvular disease. Patient used a large quantity of fatty food. Ordered plain, nutritious, solid food, to be eaten slowly, and to be well masticated; very small quantity of fluid. Under this treatment there was rapid improvement, and patient is now nearly well. Another case under his care for years, on eating to excess, suffered from attacks resembling angina pectoris. Cured by restricted diet.

In the discussion which followed, DR. GRANT (Ottawa) urged the importance of combining massage with regulation of diet.

DR. REEVE (Toronto) had frequently seen phlyctenular ophthalmia due to digestive disturbance, caused by eating too much raw fruit, especially in very young children.

DR. GRAHAM said that in skin diseases, diet was a very important part of the treatment. Many forms of skin diseases were due to errors of diet.

DR. SHEARD (Toronto) exhibited a specimen of *gangrenous bowel.* Was called to see the patient, a man aged 37, on the afternoon of the tenth day of illness; found a right inguinal hernia, with symptoms of obstruction. Hernia was reduced without much difficulty, but the symptoms of obstruction continuing, had him removed to hospital. On the following morning, Dr. Burns and himself found a soft, doughy tumor in right iliac region, thought to be impacted fæces. Gave oil and enema without

relief. Symptoms of obstruction becoming very urgent, opened the abdomen and found the tumor to be an invagination of the ilium into the large bowel, which could not be reduced. On opening the cæcum, about seven inches of gangrenous bowel was found. The hernia was entirely omental, and not in any way connected with the obstruction. The gangrenous bowel was drawn through the opening in abdomen and secured there. Patient died of shock in a few hours. Dr. Sheard considered this a suitable case for excision of the strangulated portion of bowel.

DR. OSLER looked upon this as an example of cases in which recovery sometimes takes place by the sloughing of the piece of small bowel invaginated. In cases of impacted fæces, with acute symptoms, would give opium in preference to purgatives.

DR. MULLIN said that in cases of obstruction from any cause, he would treat the acute symptoms in preference to operating.

DR. BOTSFORD (St. John, N.B.) read a short paper on *Inflation of the Lungs by Abdominal and Thoracic Traction.* His method was to draw the abdominal walls forwards, thus leaving a vacuum which would be filled by air entering the lungs. By securing a large circular disc of adhesive plaster to the abdomen he thought this could be easily accomplished Had not tried it practically, but thought it would be useful in chloroform accidents, drowning, etc.

DR. MULLIN thought valuable time would be lost, and that this mode would not be found as suitable as the old methods of artificial respiration.

DR. BURNHAM (Toronto) had given anæsthetics in a great many cases. In cases of accident always relied on artificial respiration, with inhalation of nitrite of amyl. Considered the amyl a most valuable agent in these accidents. Never saw a death from anæsthetics.

DR. GRANT thought the method not practicable. In a recent case lowered the head with good results.

DR. DORLAND (Milwaukee) read a paper on *Successive Dropsies of Amnion always Specific.* In support of this theory he gave the history of six women he had attended in one or more confinements who suffered from this affection. In the

cases reported the amount of liquor amnii was calculated at from four to twelve quarts. The children were nearly all still-born, and showed very evident signs of syphilis. At some time or others of his attendance he obtained a history of syphilis in one or other of the parents. Five of the cases were treated with small doses of mercury, and iodide of potassium in their next pregnancies; and where the husband was diseased he was also put on treatment. In all these cases the subsequent children were born healthy, and the amount of liquor amnii was not excessive. Where the treatment was not continued in the second or third pregnancy, there was a decided tendency to a return of the original conditions. From a consideration of the cases given he thinks that successive dropsies of the amnior are always syphilitic. In the cases retated it could not be due to inflammation of the amnior, as there were no symptoms of that condition; and it could not be caused by hypertrophy of the heart or kidneys of the fœtus.

DR. OLDRIGHT asked if the result was not due to the absorbent action of the iodide rather than to its anti-syphilitic properties.

DR. OSLER asked if any of the children were dropsical, this condition being frequently seen with dropsy of the amnion.

DR. SHEARD asked if there were any changes seen in the placenta.

DR. MULLIN had frequently seen dropsy of the amnion, which he considered due to syphilis. How long would Dr. Dorland keep his patient under treatment?

DR. YEOMANS had seen cases of excessive liquor amnii in healthy women, where there was no evidence of syphilis.

DR. DORLAND replied that none of the children were dropsical. No appreciable changes in the placentas. Would keep the woman on specific treatment from the second to the seventh month of pregnancy.

The section then adjourned.

The section again met at 7 p.m., Dr. Graham in the chair.

DR. DUPUIS read a paper on the *Conduct of Medical Men Towards each Other, and Towards each Other's Patients.* He condemned the practice of the British rule of the new comer calling on those already settled in the place, and likened it to two

pugilists shaking hands before they fought. When a patient asks for a consultation, he should choose the medical man to be called; when the doctor asks for the consultations he should choose the consultant. He should strongly favor having the consultation held in the presence of the patient and his friends. Held that one may give an opinion to another man's patient even when the practitioner called is continued in charge of the case and without consulting with him. He then went on to say, "Take all the cases you can get, and keep them if you can without reference to the previous attendant." Considered it perfectly justifiable to report one's cases of operation or extraordinary cures in the papers, and asserted that this was different from advertising. Why should not medical men report their cases as well as the lawyer his speeches, or the clergyman his sermons. He was not aware until informed by Dr. Osler that Canada had a Code of Ethics. His views were very strongly condemned by Drs. Harrison (Selkirk), Osler and McCammon (Kingston).

Dr. CANNIFF was surprised that Kingston appeared to know so little about the Code of Ethics, as his presidential address two years ago had dealt exclusively with that subject, and had been published in the medical journals.

DR. OLLIVER (Kingston) said the Kingston practitioners knew the Code and most of them observed it faithfully. Moved the adjournment of the discussion. Carried.

DR. METCALF, Superintendent of the Kingston Asylum, read a paper on "*The Use of Hyoscyamine in the Treatment of Mental Diseases.*" He uses Merc's crystallized, and says it is the only reliable hyoscyamine. Used hypodermically, it acts more quickly and surely than any other narcotic. A full hypodermic dose is gr. $\frac{1}{10}$ for an adult male and gr. $\frac{1}{15}$ for an adult female. After the injection of a full dose, the pupils dilate, face flushes, pulse and respiration at first accelerated, then slowed, mouth becomes dry, feeling of giddiness, distances are not calculated well, articulation becomes imperfect, and patient soon falls into a sound sleep that lasts from six to eight hours, from which he awakes complaining of dryness of the mouth, but much refreshed. Maniacs require larger doses than melancholics. Hypodermically, it usually acts in twenty minutes; by mouth, in about an hour. Another reason for giving it hypodermically is, the dose is much smaller, which is a consideration, as it is very expensive. It should be given once a day, the dose to be increased slightly by use. It is said to impair the appetite, but Dr. Metcalfe doubts this. He has not seen any increase in the quantity of urine, as is usually stated. He gave the history in

detail of numerous cases of acute mania in which the attack was cut short by the use of this drug. In one case of recurrent mania, in which the patient was very noisy, refused food, and ordinary sedatives had no effect, a few doses of hyoscyamine were used with great benefit. In another case of acute mania, in which bromides and chloral failed, hyoscyamine acted rapidly and satisfactorily. In cases where it failed to cut short the attack, it usually ensured a good night's sleep, and no ill effects followed its use. It fails in a certain number of cases, but in these no bad results follow. It is most satisfactory in recent cases of acute mania. If no good results from a few doses, he discontinued its use. Had not used it in *delirium tremens*, but thought it would act well. He related a case of puerperal mania of months standing, in which it acted very rapidly, and patient made a complete recovery. He had no faith in chloral in acute mania.

DR. HURD, Superintendent of Asylum, Pontiac, Mich., added his testimony to that of Dr. Metcalfe of the benefits of hyoscyamine in acute mania. He considered it of great benefit in melancholia, especially where there is refusal of food. In melancholia, he gives from $\frac{1}{75}$ to $\frac{1}{50}$ gr. by mouth. Would not give it in fatty degeneration of the heart, as it is very depressing. While taking it the appetite improves; but as soon as it is withdrawn, the appetite fails again. He has seen choreiform movements result from its administration, but they disappeared as soon as the drug was stopped.

DR. CLARKE, Toronto Asylum, thought it should be more frequently used by general practitioners in cases of melancholia and puerperal mania before sending the patient to hospital or asylum; large doses of Tr. Hyoscyami might be used; would give as much as ʒi to ʒiss in a dose. Did not think it acted as well in melancholia as in acute mania.

DR. THORBURN (Toronto) would not use the large doses of Tr. Hyoscyami recommended by Dr. Clarke.

DR. TROUTMAN (New York) testified to its good effects in acute mania. In acute delirium, with dry tongue and muscular tremors of some days standing, he thought it was directly contraindicated; also contraindicated in general paralysis. He considered muscular twitchings during sleep an unfavorable symptom.

DR. METCALF did not attach much importance to muscular twitchings; had seen no bad results follow.

DR. RODGER (Montreal) took the chair, and DR. GRAHAM read a paper on "*Leprosy in New Brunswick.*" He stated that he had gone to New Brunswick to study the origin of the disease, and to settle in his own mind, as far as possible, its

present mode of propagation. He found the settlers about Tracadie very poor, houses miserable, food poor in quality, consisting chiefly of fish, bread and potatoes. The first settlers were quite free from the disease, and it was said to have first appeared in a family in 1820. This family came from Caraquet, and there was no previous history of the disease in the family; it was attributed by them to having washed the clothes of some shipwrecked sailors. Dr. Graham then related how the disease spread in this neighborhood, attacking persons who were in no way related to the first sufferers. He mentioned many cases to show that the children of leprous parents were not always attacked with the disease. He said there were four ways in which it may be propagated—1, From endemic causes; 2, contagion; 3, heredity; 4, contagion and heredity. It is not endemic, because the same climate, food, and mode of living is similar over a large area where the disease has never appeared. The writer, from the history of the cases, thinks it is purely contagious, many persons being attacked with the disease in whose family no previous cases had occurred, and, again, many leprous persons having healthy children. Many persons in constant attendance on the cases have not contracted the disease; but this is seen in other contagious diseases. In conclusion, the writer said—1st, The origin and early spread of the disease cannot be accounted for by heredity, though it may predispose. 2nd, Mode of life cannot be the cause, though it also may predfspose. 3rd, It is contagious and brought from without, and, finding suitable material, is spread from one to the other. In order to contract it, a low state of the system and lengthened and prolonged contact with leprous persons is necessary. Certain families appeared predisposed to it.

Remarks were made by Drs. Grant, Roddick, Clarke, Hurd and Hingston.

The section then adjourned.

Surgical Section.

The section organized at 2.45 p.m., Dr. Tye of Chatham in the chair. Dr. Gardner of Montreal, secretary.

After a few remarks, the Chairman called for Dr. Fenwick's paper on "*Imperforate Anus, with Fœcal Fistula.*"* The reader of the paper first described in general terms the various forms of this anomaly, and then reported a peculiar case he had recently met with, and on which he successfully operated. A colored drawing in illustration was exhibited.

* This paper will be published in a subsequent number of this Journal.

DR. MCLEAN, Professor of Surgery in Ann Arbor University, thought the case a very rare one, and congratulated Dr. Fenwick on the excellent results of the operation.

The paper was further discussed by Drs. Holmes, Bethune, Tye, John Campbell, and Prof. H. Walker of Detroit.

The next paper was by Dr. Worthington of Clinton, Ont., on "*Retroversion and Retroflexion of the Uterus.*" The condition was alluded to briefly in general terms, and then the notes of four interesting cases were given. In the third case, immediately on commencing a vaginal injection of hot water, the patient was seized with violent pelvic pain and symptoms of collapse, followed by a severe attack with symptoms of peritonitis, and lasting for many days, but ending in recovery. The cases were treated with varying amounts of success by the Hodge-Smith pessary.

DR. GARDNER said everybody who treated such cases knew how troublesome they were, and that in a certain number it was next to impossible to give relief. He alluded to a practice of Lawson Tait, who, incidentally in a few cases after the operation for removal of the uterine appendages, had raised the fundus of the uterus and sutured it to the abdominal wall. He believed the practice justifiable, and thought that, in view of the modern small mortality after abdominal section, it might, in the future, be a perfectly justifiable operation, probably quite as safe and much more successful than the practice of Erich of Baltimore and Schultze of Jena, who both had, under ether, after dilatation of the uterus, forcibly stretched or torn away the adhesions which so often prevent replacement. The division of the adhesions was more certain than their stretching. In many such cases, however, it must be borne in mind that the conditions which complicate displacements are really more important than the displacements themselves. With reference to the symptoms of collapse in one of the cases, it shewed the great care necessary in prescribing such a simple remedy as a vaginal injection of warm water. It was not necessary, in such cases, that the water should reach the peritoneal cavity. Water is a fluid foreign in its nature to the endometrium, and he believed that simple contact was enough in certain cases of susceptibility from idiosyncrasy. Analagous consequences had followed the passing of a sound through the male urethra. As regards the uterus, there is evidence to shew that the nearer the lining membrane is to a condition of health the greater is the danger of such results. He (Dr. Gardner) had now under treatment at the University Dispensary for Women in Montreal an obstinate case of chronic endometritis, in which intra-uterine injections of pure carbolic acid always gave relief.

DR. HOLMES always recommended to his patients the fountain syringe, a cheap form of which he described. He takes care that the nozzle has no central aperture. He never uses the sound to replace the uterus, but invariably places the patient in the knee-chest position, and makes pressure on the fundus. In the case of adhesions, he gradually stretched them, and in illustration related a case in which repeated attempts in this way led to success, the patient became pregnant, and went to full term.

DR. TYE related two cases of fatal results after vaginal injections which had come under his notice in consultation with other physicians.

DRS. FULTON and HINGSTON also took part in the discussion.

The next paper was by Dr. Campbell, of Seaforth, Ont., on "*A Case of Femoral Hernia.*"* The case was anomalous in some respects. The operation was not performed till three and a half days after onset of the symptoms because of certain peculiarities in the case. The patient recovered.

Dr. RODDICK thought that surgeons were sometimes too chary in the use of force in taxis. He related a case in point. It was that of a woman who has had several attacks of strangulation with the usual symptoms. He has always been able by taxis to reduce the hernia, but on two or three occasions, during his absence from town, friends of his who had seen the case for him had failed and were preparing for operation, when a further use of force succeeded in reducing the hernia.

DR. OLDRIGHT said that if taxis is to succeed it must be employed early.

DR. FENWICK had recently seen Prof. Lister, and was told by him that he (Dr. L.) cuts off the sac and sutures the edges of the incisions with good results. Dr. F. had removed the omentum in a case of double ovariotomy. The patient recovered.

DR. SAUNDERS, of Kingston, thought Dr. Roddick's advice might, if followed by inexperienced medical men, lead to dangerous results. He had seen a case in which another medical man had ruptured the bowel by efforts at taxis.

DR. MCLEAN, Ann Arbor, believed that a new era was dawning in the treatment of hernia, and that operations for the radical cure of hernia will soon be much more frequently performed than they are now.

DR. SULLIVAN (Kingston) thought it a mistake to wait for urgent symptoms before operating. He had known some cases where vomiting was absent.

* This paper will appear in full in a subsequent number of this Journal.

DR. BETHUNE mentioned a case of radical cure of hernia after a kick on the truss worn over the site of descent.

DRS. TYE and SLOAN had found it necessary in some cases to use a good deal of force in the taxis.

DR. GRANT related a remarkable instance of a tumor simulating hernia.

DR. HINGSTON also discussed the paper and related cases.

The section then adjourned.

This section again met at 8 p.m.

DR. MCDONALD, of Londonderry, read a paper on "*Paracentesis Pericardii.*" The paper dealt with a single case of pericardial effusion which produced very great distress, and was not relieved by medicinal treatment. He aspirated in the fifth intercostal space near the normal situation of the apex of the heart, and removed thirty-two ounces of slightly turbid serum. This was followed by relief of all the symptoms. There was some reaccumulation which yielded to treatment by drastic purges, diuretics and sustaining treatment. The patient has steadily improved since the operation (now nearly three months ago.) She has an endocardial murmur. This was present before the operation. With the exception of this and slight palpitation she is in good health. Dr. McDonald felt the impulse of the heart against the point of the needle while aspirating, and would not have hesitated to lay open the pericardium if he had failed to remove the fluid with the aspirating needle.

DR. JAMES BELL, of Montreal, next read a paper on "*Resection of Intestine.*" The paper consisted of the reports of fourteen cases of experimental resections of portions of the intestine of dogs, as well as three cases of different forms of disease in the human subject which had come under the writer's observation recently, and in which he thought such an operation had been indicated. Of the latter, one was a case of simple ulcer of the hepatic flexure of the colon, which ultimately produced complete obstruction of the bowel. The second was a case of strangulated umbilical hernia, and the third a case of strangulated inguinal hernia, which had undergone spontaneous cure by sloughing and opening through the skin of the groin. Extracts from recent journals were also given in which cases were reported as having been successfully operated upon by Prof. Czerny, Dr. Koeberlé of Strasburg, Dr. Wm. Fuller, of Grand Rapids, Mich., U.S.A., and others. Of the fourteen dogs operated upon, four died from the effects of the operation (but

all from preventable causes), and one escaped on the fifth day after operation and was not recaptnred. Nine recovered perfectly from the operation. Of them one died of distemper on the 18th day, another from the same cause on the 45th day, and a third from senility on the 62nd day after operation. The remaining six were killed at periods varying from one to three months after the operation, and were all at the time of death in perfect health and well nourished. From three to thirteen inches of different regions of the bowel were removed, including in one case the cæcum and portions of the gut on either side. The ends of the gut were united in some cases by catgut, and in others by silk sutures, and no attempt was made to remove the mucous membrane so as to bring the cut surfaces of the outer coat into accurate contact. The portions of bowel which had been thus united were exhibited and showed perfect union. The writer considered the operation an easy and a safe one, aud predicted that in the near future it would be generally recognized as such, and many lives would be saved by it.

Dr. Bell was highly complimented by several speakers on the originality and ability displayed in his paper. It was desirable that more papers of this character should appear before the Association. Dr. Sheard of Toronto here exhibited a specimen of intussusception of the bowel. The case was one which, in his opinion, might have been saved by an operation of the kind performed by Dr. Bell in his experiments on the dogs.

The section then adjourned.

SECOND DAY—SEPT. 6.

Meeting opened at 10.30 a.m.

Minutes of the last meeting read and confirmed.

DR. BOTSFORD reported that the Nominating Committee were prepared to present their report.

The PRESIDENT said it was usual to receive the report on the last day.

DR. FULTON read the report on *Necrology*. He reported the death of the following members during the past year:

Hon. Drs. D. Campbell, of Port Hood, N.B., and Dumouchel, of Quebec; Drs. Scott, Montreal; John Fraser, Fonthill; Edwin Henwood, Hamilton; Wm. H. Bacon, Brantford; J. N. Reid, Thornhill, formerly professor of physiology in the medical department of Victoria University; Samuel Richardson, Galt; R. H. Russell, Quebec; Milne, Claremount; S. Shaw, Dalhousie, N.B.; Jas. A. Sinclair, Colborne; L. F. Oliver, St. Ferdinand; T. R. Fraser, Pictou, N.S.; Robt. Thompson, St. Stephen, N.B.; Duncan McGregor, Winnipeg; Joseph Clark, Oshawa; James McG. Campbell, Sherbrooke, N.S.; Joshua Chamberlain, Frelighsburg, Que.; J. S. Balmer, Princeton; Fred. B.

Going, St. Thomas; A. Morin, Halifax; J. J. Clark, Barrington, N.S.; A. Kollmyer, Montreal; W. D. Ross, Pembina; G. E. Gascoigne, Brockville; J. A. Stevenson, London; Jos. A. Whyte, Montreal; Jonathan Wolverton, Grimsby; McIver, Pembroke; James A. Hunter, Newcastle; Robt. Eustace, Canso; A. Crisholm, Alexandria, Ont.; James A. Sievewright, New Westminster, B.C.; Wm. Ruddock, St. Martin's; E. Rousseau, Quebec; Norman McGregor, Lucknow, and Edward Laberge, St. Philomène, Quebec.

DR. THORBURN read the report on *Education*. He referred briefly to the summer courses about to be established in Ontario, and to the formation of the Ladies Medical College at Kingston.

Several new members were proposed and elected. The meeting then divided into sections.

MEDICAL SECTION.

Meeting opened at 11 a.m.

DR. TOBIN (Halifax) read a paper on "*Pigmentary Degeneration of the Retinæ, with special reference to its causation by consanguinity of parents.*" He gave the history of a few cases in which this disease occurred, in which no other cause could be found. After giving the symptoms and describing the microscopic appearances, he said it was progressive, usually symmetrical; the subjects were often colour blind, and it is frequently seen in deaf-mutes; most frequent in young boys. He quoted authorities to show that twenty to forty per cent. of the cases are due to consanguineous marriages. Syphilis is often a cause. Treatment is of no avail.

DR. BULLER could never trace any connection between pigmentary degeneration of the retinæ and consangninity of parents. He said there was no connection between the typical disease and syphilis.

DR. PROUDFOOT (Montreal) agreed with Dr. Buller as to cause. Most of his cases were females.

DR. FOWLER (Kingston) next showed a case of *Hydrarthrosis*, in a young girl aged 7. Began one year ago, and has been steadily increasing. Commenced in the joints of the hands and wrist, next attacked the feet, and was now beginning in knees.

DR. GRAHAM had seen a case affecting the joints of the lower extremities. Injections of iodine had proved beneficial.

DR. BURNHAM (Toronto) exhibited Dr. Mortimer Granville's "Nerve Vibration Instrument," and explained its mechanism. Dr. Granville uses it in cases in which the nerve centres are affected as shown by pain or uncontrollable movements, as in neuralgia or the lightning pains of locomotor ataxia. He thinks in these cases the pain is due to

perverted nerve currents, and that the application of the vibrator changes the currents and brings them nearer the normal. Dr. Mortimer Granville says that if he gets a case of locomotor ataxia early enough, he will arrest the progress of the disease, though he will not cure it. It is found very beneficial in cases of neuralgia and sciatica. Dr. Burnham related a case of neuralgia of sixteen years standing, from which no relief could be obtained by the usual methods of treatment; the patient was greatly debilitated, and at times the suffering was excessive. Since he commenced the use of the vibrator she had more relief than she has had for three years, and Dr. Burnham has hopes of an ultimate cure. Dr. Burnham pointed out that the instrument was only in its infancy, and that Dr. Granville hoped to see it very much improved.

DR. HURD asked if it had ever been used for the aura of epilepsy. Perhaps the result was due to a change in the nutrition of the nerve.

DR. BURNHAM could not say if the result was due to a change in the nutrition of the nerve. Dr. Granville's explanation, he said, was that it changed the nerve current; but on this point Dr. Burnham said Dr. Granville was not positive.

DR. OSLER read a paper on "*Some Features in Chronic Bright's Disease.* 1. Its latency at the outset, often simulating other diseases. 2. Peculiarities in the mode of onset of the uræmic symptoms. 3. Patients frequently die with profound uræmic symptoms, highly albuminous urine, and numerous casts, yet, on *post mortem* examination, no coarse changes can be made out. He gave cases to illustrate each. (This paper will be published later in this Journal.)

DR. GRAHAM relied most on the sphygmograph for the detection of the disease. Had seen a case a short time ago, with a very small amount of albumen, little or no diminution in the amount of urea, yet the patient died in five weeks. Thought there was a general arterio-capillary fibrosis.

The section then adjourned.

SURGICAL SECTION.

The section met at 11.15 a.m.

The first paper was by Dr. Holmes of Chatham, on "*Erosions of the Female Urethra.*"

DR. HINGSTON next exhibited a *Note-Book for Abdominal Tumors.* He had found Spencer Wells' note-book deficient in some respects, and hoped the one exhibited would be found to present several improvements.

DR. MAJOR of Montreal then read a paper on "*Pharyngo-Nasal Growths.*" The author said these were very common, much more so than generally supposed. They often accounted for the symptoms of naso-pharyngeal catarrh. The commonest form met with is the adenoma, which usually consists of soft pendant growths, easily removed with the finger-nail. Another form, rarer, much more formidable, because it tends to recur after removal, is the fibroma. It is firm in consistence, and pink-colored. From the frequency with which arachnitis has followed avulsion of such growths by forceps, Dr. Major preferred the Jarvis' snare.

DR. OLDRIGHT of Toronto then read a paper on "*Fibro-Myxoma,*" containing the report of a case of tumor of this kind that he had removed from the thigh of a woman. The lobes of the tumor extended between the muscles, and the whole growth came out, leaving the muscles and other structures clean.

DR. SHEARD of Toronto, in speaking of the prospects of recurrence after removal of these growths, said that if sarcomatous elements are present, recurrence is probable, but not invariable. Bad conditions of system or surroundings of the patient favor the development of the more lowly organized cell-elements of the growth, with tendency to degeneration and recurrence. Strong constitutions, on the other hand, tend to develop fibroid growth, with less tendency to recur.

DR. PROUDFOOT read the next paper, on "*Color-blindness.*" This affection was described a hundred years ago, but it had received comparatively little attention till within a few years past. Helmholt's theory of this affection was discussed, and the dangers to life and property from the inability of railway and steamship employés to appreciate color-signals alluded to. Dr. Joy-Jeffries of Boston had done much to draw public attention to the dangers from this cause, and the necessity for examination by experts of all candidates for positions in which the capacity to detect colors is necessary. Legislative acts, with necessary provisions, are in force in Germany, Great Britain, and several of the States of the American Union, but no such act has, as yet, been discussed in the Canadian Legislature.

The hour for adjournment having arrived, the following papers were read by title :—

"Common Errors in Ophthalmic Practice," by Dr. Buller, Montreal.
"Notes on Intra-uterine Growths," by Dr. Gardner, Montreal.
"Spindle-celled Sarcoma," by Dr. Sheard, Toronto.

The third day was taken up with general business and election of officers. The proceedings will appear in our next number.

CANADA

Medical and Surgical Journal.

MONTREAL, SEPT., 1883.

ENDOWMENT OF McGILL MEDICAL FACULTY.

Our readers will remember that at the opening lecture of the McGill Medical Faculty last October, Dr. Howard urged upon the citizens of Montreal the necessity of an endowment fund, if the school was to advance to a position in keeping with the rapid development of the science and art of medicine. At once a generous friend offered $50,000 if a similar sum were raised by August in commemoration of the long services of Dr. Campbell. We are gratified to be able to announce that somewhat more than the required amount was collected, and the anonymous friend, who turns out to be the Hon. Donald A. Smith, has fulfilled his promise; the fund to bear the name of the "Leanchoil Endowment," while the other amount collected by the Faculty will be known as the "Campbell Memorial Fund." With the interest accruing from $100,000 many important improvements can gradually be brought about which will greatly increase the teaching facilities. Nothing definite has as yet been arranged concerning the disposition of the funds; but it is probable that for a few years, at least, the interest will be devoted to general purposes. The new Dean is to be congratulated on the success of the movement which has been due in no small measure to his energy and influence. Let us hope that this is but a begining, and that others, stimulated by the example, will give generously to our medical colleges.

WHO IS HE?

It appears from an editorial in the *New York Medical Journal* of Sept. 8th that we have in our midst an unappreciated genius who, being neglected at home, is seeking a wider and more congenial field abroad. This prodigy, it seems, sent a letter, accompanied by a card, setting forth all his *honors* (*!!*) and qualifications, to a prominent New York physician. He states in his letter

that he is willing to serve as an assistant to some eminent practitioner. He yearns particularly for New York, but has no objection to Baltimore or Washington. His failure at home (Montreal) he attributes to the narrow notions of Ethics that prevail in Canada, whereby physicians are prevented from acquainting the public of their great abilities by the various means made use of by persons in other spheres of life. He feels the germs of greatness in his soul, and all he wants is a "chance." The *N. Y. Medical Journal* advises our yearning and aspiring genius to give up his dream of American license, and suggests that it would probably be better for him to shorten sail at home. We should advise him to set sail for the Far West, where no ethical restraints are imposed, and where geniuses are never entertained unawares. We should like our friends on the other side of the line to understand that the use of "reduced bills for cards" is quite as much frowned upon by the profession here as in the older communities in the United States, and that the card of our disappointed, but ambitious, fellow-citizen is as much a curiosity to us as it is to them. The card, as given in the *New York Medical Journal*, we print below:—

———, M.D.,
PHYSICIAN, SURGEON,
——— Street, Montreal.
Graduate in Medicine, 1863, ——— University.
Licentiate 1863, Member, 1868, College of ———, L.C.
Member 1869, College of ———, Ontario.
Member 1881, ——— Society, Montreal.
Senior ——— Board of Health, Montreal.
Director Canadian ——— Institute.

Treats Specially:

NERVOUS DISORDERS IN BOTH SEXES, NERVE EXHAUSTION, INEBRIETY, AND DISEASES OF WOMEN AND CHILDREN.

CANADA MEDICAL ASSOCIATION.

The Kingston meeting was on the whole very successful. The number in attendance fell somewhat below the average, but all sections of the country were fairly represented. The local committee had made excellent arrangements for the reception of the association, and ample accommodation was afforded by the new buildings of Queen's College. Unfortunately the largest hotel in the city was closed for repairs, and good quarters were difficult to get. Dr. Mullin made an admirable President, and under his guidance the general meetings passed off very harmoniously. In the sections a number of good papers were presented, which elicited full and animated discussion. Dr. Graham's paper on Leprosy at Tracadie, and Dr. James Bell's on Resection of the Bowel, seemed to be the

most highly appreciated. In the Medical Section Dr. Dupuis' communication on Medical Ethics caused no little commotion. It struck at the root of all principles of professional conduct, and under a proper system of supervision of papers its presentation would not have been allowed. We sincerely hope that the Doctor's practice is better than his profession. The excursion among the Thousand Islands tendered by the local physicians to the Association was a most delightful affair in which some two hundred joined. Montreal is to be the next place of meeting, and it is hoped that arrangements may be made to hold it just before the British Association for the advancement of science in order that members may remain and take part in that gathering which will embrace many of the leading medical men of England. A warm invitation was received from Winnipeg to meet in that city, but the general feeling was in favor of Montreal. The result of these meetings is not expressed in the amount of work done—that is often the smallest part. More important, deeper and far-reaching is the influence exerted by the social intercourse of men from all parts of the country. New friendships are formed, old ones cemented; sectional differences and jealousies are forgotten, and men return to their work stimulated and refreshed.

MILITIA SURGEONS.

The militia surgeons attending the Kingston meeting, took advantage of the occasion to discuss their grievances. The following recommendations presented by Dr. Thorburn to the Canada Medical Association, received the approval of the meeting. We feel sure that the courteous Minister of Militia will do what he can to have these matters put in order.

1. The organization of a militia medical department, with a chief medical officer at headquarters.

2. That the senior medical officer in each military district be appointed principal medical officer.

3. That substantive rank be granted to all military medical officers.

4. That the medical department shall be supplied with all necessary equipment for the use of the force when required.

5. That it be further submitted to the honorable, the Minister of Militia, the advisability of changing the titles and designations of Canadian medical officers, so that they will correspond with those held by the medical officers of the British service; thus, surgeon instead of assistant surgeon, surgeon-major instead of surgeon, brigade surgeon instead of surgeon-major, deputy surgeon-general, etc.

6. That the scale of pay and allowances of the militia medical department be assimilated to that of corresponding ranks of the British medical department.

THE CANADA SANITARY ASSOCIATION.—At the close of the medical convention about fifty doctors and laymen met and organized the sanitary association as had been suggested at the Health Convention at Ottawa in December last. Dr. Sweetland, of Ottawa was elected President, and Mr. Boxer, of Montreal, secretary-treasurer. An executive committee was formed and arrangements made for actively carrying on the work of the society. Medical men wishing to join are requested to send their names to Mr. Boxer, C.E., Montreal.

PRINCIPAL DAWSON.—After more than a quarter of a century of continuous labour on behalf of McGill University, Dr. Dawson has gone abroad for a year to seek a much needed rest. We trust that he will return to his duties refreshed in mind and body, and be long spared to the University, over which he has so long and successfully presided. On the 5th inst. a number of Citizens met and presented Dr. Dawson with a purse of $5,000 as a mark of their appreciation of his efforts in the cause of education in Canada.

Personal.

Dr. Hurlburt has removed to Mitchell, Ont.

Prof. Pancoast, of Philadelphia was in town for a few days,

J. M. Dunsmore, M.D. (McGill, '70), has removed from Mitchell to Philadelphia.

Dr. Groves, of Carp, Ont., was in town last week on his wedding tour.

Ovide Martel, M.D. (McGill '83), has begun practice in St. Urbain street.

J. S. Smiley, M.D. (McGill '80), has removed from Rawdon, Q., to Portsmouth, Iowa.

Dr. A. A. Browne has returned from a tour of inspection of the Lying-in-Hospitals of Great Britain and Germany.

Dr. H. P. Wright, of Ottawa, returned from Europe with Dr. Browne.

Dr. G. A. Sihler (McGill, '83), has gone to Europe to complete his stndies.

Arthur Storrs, M.D. (McGill, '76) is practising at Wexborough, York, Eng.

Dr. Fenwick has returned from England, where he attended the British Medical Association.

R. H. Klock, M.D. (McGill, '82), of Alymer, Q., has gone to Port Arthur to join T. J. S. Smellie, M.D. (McGill, '77).

Sir Wm. MacCormac, surgeon to St. Thomas' Hospital, London, was in the city last week.

F. G. Finley (Primary Class, McGill, '82-3), recently passed the Intermediate Examination for the degree of M.B., London, Eng.

Thomas Cook, for the last thirty years janitor to the McGill Medical Faculty, owing to increasing infirmities, has been pensioned by the Faculty.

Dr. Roddick sailed for Europe on the 8th. He will be absent for a year. Dr. Shepherd will take his clinical classes during the winter session at the Hospital.

Dr. Walsh, of Washington, editor of the *American Retrospect* spent a couple of days at the Windsor. While here he visited Dr. Bessey's vaccine establishment.

Professor A. P. Simpson, of Glasgow University, was in town for several days, and visited the schools and hospitals. He went on to the Rocky Mountains with the C.P.R. party.

Dr. James Stewart, the new Professor of Materia Medica and Therapeutics in McGill College, returned from Vienna on the 3rd. He and Dr. Osler have taken Dr. Roddick's house during the latter's absence in Europe.

Dr. Hurd, Superintendent of the Asylum at Pontiac, Mich., visited the Longue Pointe Asylum lately, and then went on to the Association meeting at Kingston. He was disgusted—as are all intelligent physicians who know anything of it—with the way in which the institution is conducted.

Dr. Graham, of Toronto, spent a few days in the city on his return from a visit to Tracadie, N.B., where he has made a most exhaustive study of the Lepers at the Lazaretto. Dr. Fox, of New York, was there a short time before him, but only spent a few hours. Dr. Graham's paper on the subject was generally acknowledged to be the most interesting one presented to the Association at Kingston.

Medical Items.

—The semi-annual meeting of the College of Physicians and Surgeons of Quebec will be held at Quebec on the 26th inst.

—The introductory lecture of the McGill Medical Faculty will be delivered by Dr. Workman, of Toronto, on the evening of October 2nd.

—The autumn Matriculation in Medicine of McGill University will be held at the High School, Montreal, on Friday and Saturday, the 5th and 6th of October.

—Dr. George H. Fox and several other New York physicians interested in diseases of the skin have recently returned from New Brunswick, where they have been making a careful study of the cases of leprosy in the Tracadia Lazaretto. These are now 24 in number, although five years ago there were 36.

—The centennial celebration of the Harvard School will take place on October the 17th. The new school building will then be opened. Dr. Oliver W. Holmes will deliver the introductory address, and a reception will be given by the Faculty. Invitations will be issued to the Deans of the Canadian Faculties and other prominent medical men.

EDOUARD LABERGE, M.D. (McGill).—Dr. Laberge died at St. Philomene about the 29th ult. He graduated in 1856 at McGill College, and spent an active and useful life. He was a member of the Provincial Parliament.

THERAPEUTICS.—It must be generally admitted that the manner of the physician in the sick room must have some influence for good or for ill upon his patient; but it is something new to find rules for conduct at the bedside included within a systematic course of therapeutics. We find this, however, laid down as a part of the course in one of our Canadian schools.

THE "JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION."—Those in charge of this undertaking, which was decided upon at the recent Cleveland meeting, have lost no time in rendering it an accomplished fact. It is a 32 page, of about the size and somewhat the make-up of the *Medical News*. We are glad to welcome this new weekly, which is certain to receive extensive support throughout the Union, and has a fine future before it. Of course, of the actual value of the contents we cannot judge, until fair time has been allowed to get into good working order.

—When you examine the hand of a patient, and find on it the evidences of palmar psoriasis, be that hand the jeweled and perfumed one of a queen or the dirty paw of a beggar, it is the hand of a syphilitic.—*Hebra.*

—Particular attention is drawn to advertisement of Medical Practice for sale, on exceedingly favorable terms, in a rising town of over 3,000 inhabitants. To a young man such an opportunity as this only occurs once in a lifetime.

CANADA

MEDICAL & SURGICAL JOURNAL

OCTOBER, 1883.

Original Communications.

INTRODUCTORY ADDRESS TO THE FIFTY-FIRST SESSION OF McGILL MEDICAL FACULTY.

By JOSEPH WORKMAN, M.D. (McGill, '35), of Toronto.

Mr. Dean, Members of Faculties, Ladies and Gentlemen,—Should I omit to tell you that the embarrassment under which I to-night labor in appearing before you as the inaugurator of the 51st lecture-course of your school is not very much alleviated by my sense of the honor conferred on me by the distinguished Faculty who have invited me to assume the pleasing function, I would be alike unjust to my own feelings and insensible of the paternal—may I not rather say *filial?*—affection so generously manifested towards me on the auspicious occasion of the entrance of this now vigorous and prosperous school on its second half century of honorable labour. I am not, indeed, oblivious of the fact that for this happy privilege I am indebted certainly neither to my professional reputation nor to my large scientific acquirements, but to the stern fact of far advanced age, coupled, however, with that which I regard as an honor of high distinction—the circumstance of my being, with one exception, or, as I would hope, two, the oldest surviving graduate, not only of this medical *school*, but of the University of McGill *College* itself, for, as you must all well know, the Medical Faculty was not its first-born offspring, but was virtually and undeniably its nursing mother. It should never be forgotten that McGill College, as a teaching, living institution, was for many years known only through the energising vitality infused into its

crushed and torpid stem by the engraftment on it of the Montreal Medical Institution, of which this school is the direct lineal descendant. To the far-seeing sagacity of the men who accomplished this initiatory work may fairly be ascribed the honor of rescuing from oblivion, if not, indeed, from germinal death, the seedling erewhile committed to a soil not then well prepared for its reception and nutrition by the generous and patriotic James McGill; but there is in every good deed an element of vitality which would often seem successfully to resist inimical influences, and to endue its possessor, as in the wheat-grain long stored away beneath the swathings of an Egyptian mummy, with a marvellous faculty of renascence. Still, we know that the hidden thing must be brought under the sun's genial rays, and skilfully and sedulously cultured. This has been the good fortune of McGill College, which, by the energy, ability and noble devotion of the teachers in its various instructional departments, has attained an eminence beyond the most sanguine expectations of its founder and its early friends. Surely to have lived to see what I have seen, and what I now see, of the growth and prosperity of my *Alma Mater*, is a boon calling for my thankfulness to a gracious Providence. Most truly may I say, "*Nihil habeo quod accusem senectutem*"; for when all this pleasure has fallen to my lot, and when now the consciousness of senile decadence is mitigated by the manifestation of the tender politeness of robust manhood and aspiring youth, must not my present happy experience neutralize all regret over declining mental vigor? May this experience, gentlemen, await you all! It is well worth living for; yes, it is well worth living for, through even a battling, worrying life. Yet, as no pleasure is exempt from some element of associate or resulting pain, so now do some mournful reminiscences press in on my retrospect of the long past, when I view the many blanks in the roll of early friends connected with this school, both in the relation of teachers and pupils. Most truly, "*Pallida mors æquo pulsat pede pauperum tabernas, Regumque turres.*"

Long since have passed away the venerated men under whose instruction I took my seat three and fifty years ago, on the

modest benches of this school, in its infancy. They are gone, but their memory yet lives. I can still vividly recal the cheering placidity of the Nestor of the enterprise, to whose wise counsels and far-seeing predictive sagacity this school, and McGill College too, owe much more than has ever yet been accredited to him. Need I say that I allude to Dr. William Robertson? True it is, that he was not the Achilles of the longer than ten year's siege that preceded the surrender of the "Burnside" citadel, but he certainly was the able engineer who planned the lines of approach from which the final assault was to be made. In saying this, I detract not from the merits of my talented preceptor, Dr. John Stephenson, for from him I learned how valuable were the services of Dr. Robertson, who had, indeed, been his earliest medical preceptor. But valuable as were the wise counsels of Dr. Robertson in the founding of the medical school of McGill College, and in its early administration, I am abundantly warranted in stating that his services as a solid, reflective and painstaking teacher of the branches successively assumed by him were even more contributive to the ulterior success of the school. Would that, in corroboration of this frail tribute to his educational competency and zeal, I could now appeal to the testimony of others who profited by his wise and thoroughly practical precepts; but they are no longer here. I know, however, how highly they appreciated his abilities and acquirements, and I also know how valuable in after years were found his thoughtful, practical, and truly paternal instructions. In truth, we all regarded him with filial veneration.

Of the services of Dr. Stephenson, I know not what to say commensurate with either their efficiency or the irrepressible zeal and unflinching courage with which he performed them. We are told by some historians that Queen Mary (the Tudor) said to her courtiers that her heart, if examined after death, would show the word "Calais" engraved on it. If such a pathological finding may fall within the range of imaginative anatomy, we might poetically affirm that McGill College must have been legibly inscribed on the heart of Dr. Stephenson, for it constituted the warp and woof of his thoughts by day, and of his

dreams in the night; but not, as Queen Mary, was he fated to weep over the loss of the fortress. It was his fortune to realize the final success of his strenuous efforts; and though he was too early called from the scene of his labors, he lived long enough to see the object of his cherished hopes established on a secure foundation; and though the noble structures now held by your *Alma Mater* have been erected since his era, I would almost dare to say to those enquiring for his veritable memorial, as was sculptured of Christopher Wren—

"*Si monumentum quæris, circumspice.*"

I well remember his laments over the blank indifference, the chilling discouragements, and sometimes even the ill-disguised sneers he encountered in his earnest work, and these, too, in quarters from which he had a right to look for aid and encouragement. In after times, when it was seen that there was life in the thing, and some of the previously apathetic and motionless became inspired with a fervid love for McGill College, I could not help thinking how successful is success, and how inviting to flies is honey. Lord Chesterfield congratulated Samuel Johnson on the success of his dictionary, and even offered to become its future patron, but the Grub Street literary Hercules declined the honor. Just as honest old Sam *then* felt, must Dr. Stephenson many times have felt towards his new-born congratulators. He was not a man of honeyed words, but he had a good command of language, which was sometimes more forcible than flattering. This was, perhaps, rather his constitutional misfortune than his deliberate fault. He was warm in his friendships, but not always just in his resentments. His precipitancy of decision sometimes led him into errors, out of which the retracing of his steps was a task too humiliating for his self esteem; yet, with all his faults, or rather his failings, he acquitted himself, in every relation of life, with well merited general approbation.

I next come to the name of one whose memory will long be cherished, not only in this College, but in the entire community. It is that of the good, gentle, modest, patient and hard-working Andrew F. Holmes. Every industrious student that had the privilege of sitting under his instruction, or of asking his pater-

nal advice, found in him a real friend and a wise and frank counsellor. He was scrupulously punctual in all his engagements. We all knew that both in his class hours and those of his hospital visits we should lose no time in waiting for his appearance, and I doubt not that the good example thus given us by him proved fruitful in after years. Of all the qualities desirable in a medical practitioner, as, indeed, in any other member of society, none is more laudable, or more important, than punctuality in carrying out appointments. When this practice passes onward into habit, as it is in time sure to do, and when it is combined with general good order, as it was in an eminent degree in Dr. Holmes, it is sure in the end to command general respect, and to win that public reliance which more brilliant qualities, unassociated with it, often fail to secure or to retain. Of Dr. Holmes, as an honored member of society and an exemplary Christian man, eulogy, within this city, would be but intrusive supererogation. Nothing that is truly good can die. Goodness is as immortal as its Divine Author; and though men die, their good deeds live after them, and often prove abundantly reproductive. So has it been, I believe, with Dr. Holmes; and what better proof of the fact need I seek for than my present surroundings.

In reserving the name of Dr. Caldwell for the last place in this commemoration, I desire not to be understood as ascribing to him any inferior rank in the noble band of pioneers, but as he was called from life before the school had made much promising advance, and, indeed, before I took up the course of practice of medicine, I am unable to speak of his merits as a lecturer, unless in so far as I derived my information from other students, and especially from his private pupils, in whose number my lamented friend the late Dr. David was a devoted admirer, who never failed to manifest his high appreciation of the abilities and the personal worth of Dr. Caldwell. One thing was well known to us all, and that was, that Dr. Caldwell was a high-minded, polished gentleman; and I can add, for I well know the fact, that he earnestly co-operated with his colleagues in the arduous work of founding this school, and of fostering it in its struggling infancy.

and profit from them while they are within your reach; opportunity neglected is often very shy of return, or even very resentful. Procrastination is not only the thief of time, but very frequently the successful hider of the stolen treasure. Some of you no doubt purpose, after quitting these benches, to pass onward to the great schools of Europe. This is well, and your present teachers will approve of your determination; but if this expectation leads you to slight present opportunities, as in truth I have sometimes observed it to do, it would be far better that your pecuniary resources were too slender to warrant the expenditure. I am quite sure that your experienced advisers here will tell you that in order to profit well by your studies abroad, you must carry a good supply of knowledge from home, and with this the fixed purpose of persistent industry and of adding all you can to your stock.

An old English proverb, which must have been coined in France, says:

> "Send a goose to Dover,
> And he will come a goose over."

The pronoun shows that this goose must have been a gander, consequently he was not a good sitter. I have, in my time, seen a few of these anserine wanderers take wing and come back again; some rather thin of feathers, but others in full plumage, and much improved in gabbling powers. Nobody ever suspected they would come back swans. But, on the other hand, I have known many clever, hard-working young men who crossed the seas and profited largely, because they started with a good capital, which they brought back largely augmented; and with this they also brought back, not decreased, but even enlarged, their constitutional modesty. Wherever you may go, gentlemen, take care of this commodity. It is an adornment no less becoming in a physician than in a woman, and as all sensible persons know that it is most usually and most largely found in those whose large acquirements have taught them how much they have yet to learn, its possessorss must, in the long run, become, if not the richest in this world's gear, yet the richest in the good opinion of all those whose esteem is worth striving for.

It is a most gratifying fact, and, indeed, one of which Canadians should feel proud, that so many of our young men have acquitted themselves with honorable distinction in foreign schools. We may rest assured that these devotees of science have striven, not alone to win honor to themselves, but to add more to their colleges at home. This is a noble proof of laudable ambition and true patriotism; let us hope that it may continue to be often exhibited, for we have a country worth honoring and loving, a grand inheritance, which we must well guard and cultivate, that we may hand it down, not merely unwasted, but amplified and enriched, to posterity.

I might here, young friends, close what I have to say to you, for though your venerable Dean, in his letter of invitation to me, made a good-natured allusion to my quondam experience as a medical teacher, I have not the hardihood, in the presence of those who constitute your professorial staff, to offer a word of suggestion as to the manner in which you should apply yourselves to the study of the various branches which you will have to master. You are in the hands of able, learned and honorable men, who will fail in nothing that may tend to your best interests. There is, however, one subject on which I would detain you for a little longer, and it is one on which my age and prolonged observance have given me some pretensions to speak with strong conviction. What I desire to say more immediately concerns those of your number who are nearing the close of their studies, and are naturally looking anxiously forward to the time when they shall take their position in the ranks of authorized practitioners of the art of medicine, but as I shall never have another opportunity of addressing you, I would request that you will all give kind consideration to my words.

I would then beg of you that you will, when you enter the field of practice, carry with you, into it, some adequate protection against the misfortune of idleness. Do not flatter yourselves that a host of sick people will be waiting for your kind attentions or your superior skill, or that those who are in good health will endeavour to become sick, in order to recruit your slender finances. You will have much wearisome waiting, not merely

for patients, but, alas! for the payment of your hard-earned fees; you will have many an hour of trying expectation, not less trying than that of a spider, yearning for the visit of a hunger-relieving fly. Learn, then, a lesson from the spider, for spiders are sagacious artists. I here allude to their skill in weaving, not in killing, which you had better not imitate. They are very close stayers at home, and they never keep a decent caller long waiting at their bell-pull. I cannot tell you how they contrive to while away their waiting hours. Most probably a good deal of it is spent in that physiological process which psychologists now call unconscious cerebration, but it is very reasonable to believe that they are then elaborating new material for use in future exigencies. In this operation you may profitably imitate them, but your cerebration had better be of the conscious sort. We know more of what they are not doing when watching their lines, than we do of their domestic engagements. They are not smoking, nor playing cards, and nothing could tempt them out to a horse-race, a cock-fight, or a nigger dance. They may not shun taverns, for flies are plentiful there; but you may rely on it, they would prefer that these patients did not poison their blood with alcohol. You will be exactly of the same opinion, in due time, if you cultivate the patronage of tavern frequenters, for they are both bad patients and bad pay. As to the class of literature most indulged in by our arachnidian brethren, I can only tell you that it is not trashy dime novels, or newspaper politics and sensational balderdash. By none of these could their spinning powers be nourished, or their intellectual faculties strengthened. I doubt whether they have, or need, any protection tariffs, though they are very earnest patrons of home industry, and they waste no time in bunkum speeches in election contests. They are profound believers in the virtue of anæsthetics, but you had better not push these pain-killers to the lethal extent which they prefer.

Now, as regards young medical practitioners, but especially those who settle in rude rural districts, in which society is necessarily of the least cultivated order, it has been my painful observance that too large a proportion fall into habits of idleness,

intellectual and moral torpor, and ultimately confirmed dissipation; nor, in truth, have these unfortunates been, in general, the least promising, or the least talented, members of the profession. I could furnish a far too numerous list of names that once ranked high in their several classes, and did honor to themselves and their teachers, but who—some sooner, some later—dropped out of the ranks of the respected, and passed out of life, sad wrecks of both physical and mental powers.

How are we to account for these calamities? Are there no means by which they may be averted? Before we can pretend to approach the treatment of any disease, it is indispensable that we understand its causes, both remote and immediate, as also the pathological results of their operation. In the cases now in question, we see but too clearly the morbid processes in progression; and both the ante-mortem and the post-mortem revelations convince us of the impotency of treatment. Prevention, we are certain, is everything; cure, nothing. We must begin at the beginning, and try to strangle the lurking foe. We must not wait to kick him out, for his posteriors are kick-proof. Keep him out, and kill him there, while he is killable.

Now as to these maleficient causes, we can hardly hope to unearth them all, for they may sometimes be both numerous and complex. I shall therefore restrict my observations to but a few of those which appear to me most prominent. I do believe that not the least potent one is the persistent mental overstrain undergone by some students of feeble enduring powers in their college courses. Having applied themselves too intently and too hurriedly to the proper subjects of their training, they become, at the end, utterly tired out, and, once liberated from their drudgery, they revolt against any resumption whatever of their past studies, despite the fact that on graduation day they may have been told by their zealous and well-wishing Dean that they must ever continue students, or, indeed, that they must consider their real studies as only then beginning. All this is very good, and beautifully sentimental, but, somehow or other, jaded brains, as well as tired limbs, ache for rest, and weakened mental stomachs call, at the least, for some change of diet. Change of mental aliment

might, in these cases, work admirably, but how or where is it to be had? The libraries of young practitioners are not redundantly stored with volumes of classic literature, nor even with those on scientific subjects in affinity with their own; and rural libraries, where such really exist, present but a meagre number outside the run of sensational novels, distensively padded biographies, and wonder-filled travels. As to congenial, improving, intellectual society, any such hypothesis, in the villages and bush settlements of Canada, or even in the richer agricultural parts, would be too ridiculous a delusion to be indulged in by any one outside of Bedlam. What, then? Must our young Æsculapeans, forced into wilderness exile and benumbing monotony because of the want of elbow-room in the cities and towns, be hopelessly doomed to mental, moral and physical degeneracy? Surely not. Surely adequate prophylactic means are available for their protection from the destructive virus. I rejoice to see that three lessons per week are given in this school in the enticing field of Botany; and could I only know that the lectures of your distinguished Principal on Natural History were faithfully followed by all medical students, my hopes of their future safety would be strong. Show me a young man who is a lover of Botany, Zoology, or Geology, and I will feel assured that he will never be an idler, nor even be at a loss as to how to fill up his spare time both pleasantly and profitably. He will find beauty and marvellous order and design in every, even the lowliest, flower or leaf, the meanest insect, the coarsest pebble, or the most unseemly rock in his pathway,—in short, "books in the running brooks, sermons in stones, and good in everything." Would not mental food such as this prove admirably nutritive and recuperative to overworked brains, and infinitely more conducive to professional success and the conservation of pecuniary resources than smoking, card-playing, horse-racing, and all that ilk, ending in never-failing tippling? In good, solid literature, another most valuable resource will be at the command of those whose domestic and academic education has prepared their faculties and taste for its appreciation; and as all medical stndents are supposed to have acquired a passable

knowledge of at least one of the ancient classic tongues, they cannot fail, after diligent attention to the grand models here presented to them, to appreciate elegance of diction, clearness and purity of style, and verbal frugality.

A correct knowledge of the structure of the Latin language will serve as an easy introduction to its four descendants—the Italian, Spanish, Portuguese and French, and irrespective altogether of the rich literary treasures to be found in these, the very process of studying their structural peculiarities, their distinctive powers, and their interesting affinities, can never fail to be a source of real pleasure to every one who embarks in this improving study. It is a great mistake to regard such work as a heavy task. I know of none more easy or pleasant.

As regards preserving fresh in the minds of students their acquaintance with the ancient classics, I cannot do better than to reproduce here an advice, which I well remember, given by Dr. Robertson in an opening lecture of this school. It was, that his hearers should every day read, at least, a page in some of the authors studied by them in their academic course. This, he said, he had made his own rule, and it had become to him a source of real pleasure. I have followed Dr. Robertson's advice as faithfully as possible, and I have no hesitation in now handing it down to you, as that of a clever and worthy man.

Most of you, I presume, have read with admiration those delightful words of Cicero, in praise of refining studies, in his defence of the poet Archias:—

"*Haec studia adolescentium alunt, senectutem oblectant, secundas res ornant, adversis perfugium ac solatium præbent, delectant domi, non impediunt foris, pernoctant nobiscum, peregrinantur, rusticantur.*"

Yes, it is beyond all question, that "those ennobling and refining studies, which nourished the young, will give pleasure to their old age; they will ornament prosperity, and prove a refuge and solace in adversity; they will be charming at home, and not embarrassing abroad; they will be interwoven in our dreams, bear us company in our travels, and tarry with us in our rustic relaxations."

I have said nothing to you of the protective influence to be derived from sound religious instruction and unswerving faith

in your Heavenly Protector. The function of inculcating these pertains to another order of preceptors, whose ministrations, I take it for granted, you have been early taught to seek, and to defer to with reverential respect. Nothing that I have said will, I trust, be found at variance with their teaching.

May I now, gentlemen of the Faculty, indulge in a few prophetic words embodying my present anticipations of the future of your school and its thriving motherly daughter, the University of McGill College; but in anything I may say, I must entreat you not to suppose that I am at all indifferent to the claims on my respect and fealty of the educational institutions of my own long adopted province. My heart is warm to all, but I cannot forget my first love. For whatever professional competency I had to start on, or whatever success fell to my lot in after years, I was indebted to the able men who, under such an array of difficulties and discouragement, founded this school. You may, then, well believe with what hearty satisfaction I have watched your prosperous course.

Your distinguished Principal, Dr. Dawson, once, within this College, expressed to me his deep regret that McGill University labored under the disadvantage, as compared with ours of Ontario, of having had no governmental endowment. I replied that my views in this direction differed from his; for it was my apprehension that the very amplitude of the primary (and shamefully mismanaged) endowment of ours would eventuate in its ulterior indigence. What are the facts? Whilst yours has again and again been receiving munificent donations and bequests, ours has fallen heir to nothing from the dead, and has received very little from the living. Within the past two years we have buried (not lost) three millionaires in Toronto alone. Of the dead we are instructed to speak well, or remain silent; yet is not that life which leaves nothing better to be remembered of it than the flinty fact of the heaping together of a pile of gold, a pitiable blank? Blank, then, be its memory: the charity of silence is all the honor we can award to it. What a contrast to our mole-burrow does your noble city present? Here the true value and purpose, and, let me add, the responsibility, of

wealth, seem to be understood. Your rich and generous citizens appear to consider money as valuable in proportion to the amount of good it enables them to do, and to regard themselves as faithful stewards, accountable for its disposal. By their munificent gifts to McGill College University, and to numerous other public institutions, they have won to themselves, and have conferred on the city of Montreal, an honor, of which they and all their fellow-citizens may well feel proud, and you need not hesitate to expect their liberality to be largely imitated. I do believe the tide of your good fortune has only begun to set in. Your McGills, Molsons, Redpaths, Logans, Frothinghams, Scotts, Mills, Smiths, Greenshields, Stuart-Gales—(but here I must stop, for, to enumerate all the benefactors of McGill College would require whole pages of this paper)—have but led the way. Their example will prove potently inducing, let us even hope widely contagious, though not, I trust, perilously epidemic, for a plethora of wealth is not conducive to the highest efficiency of educational establishments. I think, however, this evil will not befal you in my time. Could I but hope that the benign neurosis which promises to become so widespread here among your merchant princes and large capitalists—yes, and a goodly number of the lighter pursed—would become itinerant, and wend its way up the St. Lawrence and over our Lakes, would I not rejoice to welcome its advent, and would I not cheerfully minister to its subjects, and whisper to them that their symptoms were all promising, and their present disorder would prove eminently protective against a virulent and incurable malady which would not only torment themselves through life, but in all probability become hereditary? If any of you believe that the little nerve-modulator may be propagated by inoculation, or skin-grafting, I wish you would supply me with a little of the pure lymph, or a few small skin patches, that I might induce our physicians to make the experiment on two or three of the *élite* of our wealthy class. If the process proved successful, we could keep up our own supply, for the affection would be sure to become fashionable, and respectable too. Our fine University would then no longer have to whine over its inadequate revenues.

Among the indications of your prosperity and sagacity, I must not overlook one fact, which is truly gratifying to me, as it must also be to all my fellow provincials ; it is the appearance on your professional list of three names of former residents of Ontario, all of whom have been well known to me as able and industrious workers, and as highly esteemed members of society. It is my earnest hope, and, indeed, my firm belief, that these gentlemen will add lustre to your school ; nay, one of them has already done so, and has carried your name with honor far into both the old and the new world.

I have above given you credit for sagacity in your appointments, but I should add to this virtue—justice. Your list of graduates shows that no less than 236 of the entire number are now living residents of Ontario, or about 25 per cent. If to these we add the number deceased, the proportion would probably equal 30 per cent. These figures, taking into consideration the three able competing schools in Ontario, must be to you very gratifying, and should amply justify your recent nominations.

Having now said as much as the time allowable to the occasion warrants, I would yet crave the privilege of adding a few words in commemoration of departed friends and fellow-students, some of whom have left in this school and this city a record which requires no posthumous contribution from me.

The first graduate of McGill College was William Logie, in the year 1833. He was a private pupil of Dr. Robertson, and was well known as a young gentleman of excellent character, superior abilities, and commendable industry. Like myself, a matrimonial alliance led him out of Lower Canada.

Next to him, in 1834, came John Finlayson and Edward P. McNaughton. The former lived until a few years ago. He died in Elora, where he had practised successfully for many years. Poor McNaughton was fond of duck-shooting, and was accordingly drowned near his home at St. Anne's. He was a warm-hearted, impulsive, open-mouthed, good fellow.

I must here add, though, I am happy to say, not yet on the death-roll, the name of a very dear friend, Dr. Roderick McDonald of Cornwall, a graduate of this year, whose moral superior I have never known.

The year 1835, that of my own graduation, brings me to the name of a departed one, not to be forgotten by me nor by my good partner in life,—it is that of Pierre Dansereau, who stood as my best man on the happy occasion of my wedding, within five weeks after our admission to the doctorate of medicine and surgery. So you may suppose, young friends, I did not spend every night in my fifth year in nothing but medical studies. Dr. Dansereau was possessed of superior talents, and was an industrious and apt student. Of his personal worth, I shall merely say that he was a perfect specimen of French Canadian gentlemanhood, and this renders further eulogy uncalled-for.

The year 1836 brings me to the graduation of Lewis H. Gauvreau, William Fraser, and William Sutherland. Dr. Gauvreau was a gentleman of good parts, but he committed that sin which should never be pardoned to a medical man. He went into Parliament—a company which I advise you all to stand clear of. It is totally unsuited to doctors, unless they repudiate their vocation: and, in truth, I have been assured by old Parliamentary stagers that doctors are unsuited to it.

Of Dr. Fraser, many in this city must still preserve warm remembrance. He was a man of exemplary industry, solid, practical sense, and sterling probity. He held for many years one of the chairs of this school, and I had the pleasure of learning from his students that his teaching was most thoughtful and instructive.

I now come to Wm. Sutherland; but here words fail me, and words could not express all that I wish to convey of my admiration and esteem of this early friend. Of some persons we can say little, because we have but little known them. Of William Sutherland I know not what to say, because I knew him so well, and to know *him* well, was to love him dearly. He was the very soul of candour; his friendship was as firm as it was warm; his love of truth and of true manhood was as strong as was his detestation of duplicity and meanness. He was no changeling, and I believe all the friends of his youth continued such to the end of his too brief life. Of his service in this school, many on your roll of graduates have borne grateful testimony, and I am sure

his loss will long be deplored by your staff. Why, then, seek to add a leaf to the evergreen wreath of his memory? He is gone whither we all must follow, but while we who knew him remain, his memory will not die.

I might prolong this death roll by adding many other names, but I must already have taxed your feelings and your patience too heavily. I shall therefore mention only Walter Jones, the two brothers Charles and Edward Sewell, — McNider, Archibald Hall, and Aaron Hart David. These were students of this school, but they graduated abroad.

And now that you have so kindly accompanied me through my mournful retrospect, and looked down with me into the dark valley, I pray you to accept my hearty thanks for the privilege so considerately afforded me by you, on this auspicious and solemn occasion, of telling you how much and how lastingly I love your school, and venerate the University of which it so long has been, is now, and, as I pray, may continue to be, so honorable a department. I know I shall never again have a similar opportunity, for I feel that I stand very near the top of the roll of the survivors of life's battle, and the date of my call-off cannot be distant. And now that I find not words of my own in which to utter my present feelings, permit me to offer those of Erin's sweetest melodist:—

" When I remember all
The friends, so link'd together,
I've seen around me fall,
Like leaves in wintry weather,
I feel like one
Who treads alone
Some banquet-hall deserted,
Whose lights are fled,
Whose garlands dead,
And all but he departed."

COMMON ERRORS IN OPHTHALMIC PRACTICE.

By F. BULLER, M.D., M.R.C.S., Eng.,
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(*Read before the Canada Medical Association, September 6th*, 1883.)

No one can be more fully alive to the dangerous nature of the task I have in hand than I am myself. There are very few of us, in our own minds given to making mistakes, and still fewer willing to admit having been in error. Even to hint at such a thing is to vibrate the most sensitive chord in human nature. And yet, if ten years experience of special practice have demonstrated any one fact to me more clearly than another it is that the diagnosis of diseases of the eye by those who have not made a special study of ophthalmology, is far more often erroneous than correct. There is one disease in particular that I may say I have *never* known to be correctly diagnosticated under such circumstances, until irreparable damage had been done to one or both eyes. I allude to glaucoma, a disease which commonly presents no diagnostic difficulties that should puzzle any one possessed of ordinary powers of observation. The question arises wherein lies the fault. Is it that the profession regards the organs of vision as of so little importance as not to be worthy of attentive study? Or is it that the system of medical education in vogue up to the present time does not sufficiently cultivate the observing powers to enable men to unravel and interpret the most obvious signs and symptoms of disease?

I often find myself debating whether it is possible that in general practice there is as much error abroad in regard to diseases of other parts of the body, as in those pertaining to the eye. I would fain believe there is not; perhaps some of the other "ologists" present will kindly enlighten us upon this point. Nothing is further from my intention than to depreciate the attainments of my professional brethren, most of whom as I well know are earnest and painstaking in the pursuit of knowledge. I only wish to call attention to some points of interest to those who are obliged to engage more or less in ophthalmic medicine and surgery.

One does not require to be the son of a prophet to divine the

thalmoscopic mirror. 3rd, By the somewhat wide and inactive pupil of glaucoma, the condition of the pupil being normal in uncomplicated cataract.

Although it must be admitted that a positive diagnosis of a purely chronic case of glaucoma cannot always be made without the aid of the ophthalmoscope, it fortunately happens that any one skilled in the use of this instrument cannot fail, by its aid, to clear up any doubts that may exist in a given case, *and I therefore cannot too strongly insist that, in any case of gradual and progressive failure of vision, not due to any visible or obvious cause, an efficient ophthalmoscopic examination should be made with as little delay as possible.*

I have spoken of glaucoma at greater length than I should have done, but for the fact already stated that it is so rarely recognized in its early stages, and because, of all diseases to which the eye is liable, this one most urgently calls for an early diagnosis, for prompt and decisive treatment.

To many members of this Association it may seem incredible that a disease so common as iritis, and so marked in its character, should ever escape recognition; and yet that it does so escape far too frequently is abundantly proven by the multitudes living to-day with more or less complete posterior-synechia and damaged vision, the result of neglected or badly managed iritis.

So far as I can judge from my own observations, this affection is usually mistaken for conjunctivitis and improperly treated with astringents, such as sulphate of zinc or nitrate of silver, for these two remedies deservedly hold a high rank in the treatment of conjunctival inflammations, and are therefore almost always resorted to when inflammation of the conjunctiva is suspected. Just here I feel in duty bound to emphasize the fact that the use even of weak astringent solutions never fails to intensify inflammation of the iris; but the worst of it is that the physician who prescribes an astringent imagines that he has done all that is necessary in prescribing an eye wash that he has known to do good service in the treatment of inflammation of the eyes in many other cases, and the unfortunate patient is debarred from the use of *atropine*, the one essential remedy for the successful treatment of his disease. Inflammation of the iris is characterized

by symptoms so obvious that I cannot understand how anyone who has ever seen a typical case can ever make a mistake in the diagnosis of this disease as ordinarily met with. The change in the color of the iris, its dull, lustreless appearance, the contracted pupil responding imperfectly, or not at all, to the stimulus of light, the effusion of lymph at the margin of the pupil or in the iris, the dim vision, the peri-corneal character of the injection and the attendant pain, together with the absence of symptoms indicative of inflammation of the cornea or conjunctiva form an assemblage of symptoms that ought to put an error in diagnosis out of the question; and, besides all this, the use of a single drop of atropine will, in the majority of cases, display an irregularity of the pupil that the dullest observer could not possibly overlook. In the name of humanity, I would ask everyone who ever expects to treat disease of the eye to become familiar with the symptoms of iritis. For one badly managed attack of this disease may, and often does, ruin the prospects of a life, whereas if discovered early, and treated efficiently, absolute and perfect recovery is almost a certainty.

There is one common affection of the eye known under the general term *Asthenopia*, which constantly misleads the unwary. Asthenopia, in its widest sense, means a functional disturbance which renders the act of vision difficult and uncomfortable. It is usually mistaken for disease of the optic nerve or retina and often leads to the most alarming prognosis. The subject is too extensive for anything like an exhaustive discussion, but I may say that the majority of such cases depend on some error of refraction, on some muscular anomaly, or some fault in the general health, or in excessive use of the eyes. In most of these cases the great point is that the vision when carefully tested shows no actual impairment, and an apparent diminution of vision will often be found to depend on the existence of astigmatism, in which case a little judicious questioning will usually reveal the important circumstance that vision has never been really perfect. The chief complaint is of pain in or about the eyes when they are used for any length of time, sometimes so severe as to cause the patient great alarm, and since the affection most commonly occurs in nervous or irritable people

alarm becomes mortal terror, when, as too often happens, they are told the trouble is in the optic nerve and threatens blindness. Such people become a ready prey to unscrupulous charlatans.

Nothing can be further from the truth than the assumption that organic disease of the retina or optic nerve is characterized by pain or discomfort from using the eyes. Such lesions may be and usually are most frequently attended with persistent headache, but the ocular symptoms are inconspicuous at least until there is a considerable impairment of vision. With regard to the headache, there is one point that should, I think, be regarded as an axiom in medicine. *An ophthalmoscopic examination should be made in every case of persistent headache.*

No one with any regard for his own reputation will ever pronounce any case of asthenopia to be one of organic disease of the retina or optic nerve without having first carefully tested vision, more especially with regard to refraction and accommodation and then make an accurate ophthalmoscopic examination. For it is far better to make no diagnosis at all than to diagnosticate incorrectly.

There are some other common errors I had intended to speak of, but they are of minor importance and I will not trespass further upon the time of the Association, at the same time I have the strongest reasons to believe that the facts I have presented are quite worth the attentive consideration of every medical practitioner who has not made a special study of diseases of the eye, but whose position is such as to necessitate including these in his daily practice.

LEPROSY IN NEW BRUNSWICK.

By J. E. GRAHAM, M.D., Toronto,

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(Read before the Canada Medical Association, September, 1883.)

In order to gain a more accurate knowledge of leprosy as it exists in the Maritime Provinces, the writer spent some days in Tracadie and the immediate neighborhood. Tracadie is a parish with a population of over two thousand, situated on the coast of the Gulf of St. Lawrence, at the mouth of the Miramichi River. It, together with the parishes of Neguac, Pokemouche, and

Caraquet, forms a large portion of the peninsula immediately south of the Bay of Chaleur. The inhabitants in this region, chiefly of French origin, live on small farms, which they cultivate very indifferently. They spend the winters in hunting and fishing. Their diet is made up mainly of fish, potatoes and bread, with very little meat. They eat stale fish in preference to fresh.

In order to state what is known of the origin of the disease, it would be necessary to give a short account of the early history of the district. The first settlers in Tracadie were the Le Bretons, who came in the year 1778. They lived with the Indians, existed on the coarsest and most meagre diet, suffered greater hardships than most of those who followed them, their children intermarried with the families who afterwards came to Tracadie, and yet it is a notable fact that none of the name ever suffered from leprosy. This family was followed by two brothers, William and Thomas Ferguson, Charles McLoughlin, and Michel Basque. They came in 1785. The latter came from Acadia, as also did Joseph Sonier and family during the next year. In the few years following, a number of families came in from Acadia, some from near St. John, and some from the Province of Quebec.

Leprosy first appeared in Tracadie about the year 1820, in the person of Ursule Landry, who, with her sister Isabel, came from Caraquet about 1798, and married two brothers, the Benoits. The account generally given by the people is, that before leaving Caraquet these sisters washed clothes for some French sailors who were lepers. There are grave doubts, however, as to the correctness of this story. Ursule died in 1828; Isabel was the next victim. The third was François Sonier, who is said to have contracted the disease by carrying the coffin of Ursule Benoit. He stated to persons now living that the sharp edge of the coffin abraded the skin of his shoulder, and he thus became inoculated by matter which ran out from the corpse. The disease attacked others in the following order: Joseph Benoit, Ide Sonier, John Robicheau, Olivier Robicheau, and Cyril Austin. Frank Sonier was ill a number of years, and his father's house was the rendezvous of the young people of the neighborhood.

A number of these afterwards suffered from leprosy. He at one time attempted to go to Cape Breton to consult some person there who had a reputation in Tracadie for curing ulcers. He remained over night at the house of a Savoy in Seguac. Mary Savoy washed the clothes of the bed on which he slept, and afterwards had leprosy. This was the first case in Neguac. It is possible that other patients may have visited Cape Breton to see the same person, and this may account for the presence of the disease in that locality. Frank Sonier did not reach Cape Breton, having found himself too ill to proceed. It was not until a number of people who were intimate with the Soniers had taken the disease that public attention was drawn to it, and the lazaretto on Sheldrake Island, in the Miramichi River, was established. This was in the year 1844. At the same time, or, it is said by many, previous to the appearance of the disease in Tracadie, a Mrs. Gardiner, in the Miramichi district, 55 miles from Tracadie, contracted the disease. A man by the name of Moore, in the same district, also suffered from it. These were followed by Stewart and the Tingleys. McComb, of Miramichi, afterwards took the disease. It is said that he contracted it in Tracadie while working in the lumber camps. Some of the latter were natives of the United States.

THE PRESENT CONDITION OF TRACADIE AND NEIGHBORHOOD WITH REGARD TO LEPROSY.

There are now in the lazaretto 24 patients, whose names and histories were recorded. They came from a district within a radius of 25 miles of Tracadie. According to the report sent by Dr. A. C. Smith to the Department of Agriculture, there were, at the end of 1882, 26 patients in the hospital—11 males and 15 females. There was one death during the year, and four patients were admitted. There have been no admissions since the commencement of this year. Two deaths have occurred, leaving the present number, 24. On looking over the hospital records, it was found that the average length of time of residence in the hospital of those who died was about five and a half years. The average length of residence of those who are now in the hospital is four years and ten months. This includes one who has been 24 years and another 14 years in the lazaretto.

One Margaret Sonier, *nee* Robicheau, had the disease forty years ago. She is now 70 years old. Her history is a remarkable one. She was admitted to the lazaretto in Sheldrake Island in 1844, when it was first established. During five or six years residence there she lost all the fingers of both hands, leaving only the first phalanges of the thumbs. She was then sent out cured. She married one of the Soniers, and had three children, one of whom, Lucille Sonier, is now twenty-four years in the lazaretto. The other two never contracted the disease. In my opinion, the disease has not really returned since she first left the hospital. She has been subject during the last two or three years to perforating ulcers of the feet, one of which made its way completely through the foot. These have probably been caused by defective nutrition, a result of leprosy, rather than the disease itself. She is quite as well, and, I think, much more active, than most women of her age.

During the short time that the writer remained in Tracadie, he heard of four cases outside of the lazaretto. In some instances the disease is concealed as long as possible. Father Babineau is constantly on the watch for new cases, so that, as a rule, they do not long remain unrecognized. The lazaretto itself is kept in perfect order, and everything is done which can suggest itself to the Sisters to ameliorate the sad condition of the patients. It would be a great blessing if a new and more substantial building were erected, as the present one is old and gloomy at best.

The writer spent the greater part of his time in attempting to discover the manner in which the disease commenced and spread. There are three ways in which the origin and progress of the malady may be accounted for :

1. That it is purely of hereditary character.

2. That it originated in the country from endemic influences, climate, diet, &c.

3. That the disease is contagious, and was introduced from without. The surroundings having been favorable, it spread among the inhabitants, probably by inoculation.

4. That the disease is both hereditary and contagious.

Although the general opinion of writers on leprosy is that it is propagated by hereditary influences, yet in no case reported in Tracadie can this be satisfactorily proved. In every instance there was abundant opportunity for contagion, so that the part played by heredity could not be determined. It will be noticed on consulting the family charts which I have made, that the Sonier, Brideau, Robicheau and Commeau families were very much afflicted with the disease. It did not appear in these until after Frank Sonier became affected. It then broke out in several households at about the same time. Now these families came to Tracadie from Acadia (Westmoreland County), from near St. John, and from the Province of Quebec, where many of the same name may still be found. If the disease is hereditary, one cannot understand how members of the family remaining in Acadia should be free from it, and those in Tracadie should suffer to so great an extent. It will be seen, on looking over the hospital records, that the disease runs in families, and that numbers of the same names of the successive generations have suffered from it. This fact is rather misleading, as it will be found, on looking over the parish register, that a dozen of the names which occur so frequently in the hospital records would include at least three-fourths of those who have lived in Tracadie. It is not surprising, then, that people of the same name should be so frequently attacked; in fact, it could not be otherwise.

In order to prove that the disease may originate purely from hereditary influence, it would be necessary to have a case somewhat like the following: A husband and wife, of leprous antecedents, but not themselves victims to the disease, remove to a distant part of the country and raise a family of children, who have no communication with their leprous relatives. If any of these should suffer from the disease, it might then be said to have originated purely from hereditary influence. I have made as close a search as possible, and could find no such instance. In all the cases found outside of Tracadie, the disease had commenced before they left home. It is possible that, from further investigation, such an instance as I have mentioned may be found. It would go a long way to prove heredity. Several families have

left the country, and, so far as known, no case of leprosy has occurred among them. None of Ursule Benoit's children contracted the disease, but several of her grandchildren suffered from it. Laurence Commeau died in the lazaretto of leprosy. None of his children suffered from it, but it appeared in several of the grandchildren, two of whom are now in the lazaretto.

The second theory to be considered is its origin and progress through purely endemic influences. This may be excluded for the following reasons:

1. Along the New Brunswick coast north of the Bay of Chaleur and south of the Miramichi River there exists a people of the same race, religion, habits, occupation, and condition in life as those of Tracadie, yet none have suffered from leprosy. It is impossible to understand how the disease should have arisen from endemic influences and be confined to this peninsula.

2. The man McComb was of a different race from those of Tracadie, and lived under different circumstances in Miramichi. He came to Tracadie to all appearance healthy, caught the disease, and died of it. There is little doubt but that diet, mode of life, &c., may develop a tendency to the malady, but the evidence, so far as could be gathered by me in Tracadie, was quite opposed to its purely endemic origin.

The theory of contagion is shewn in many ways. The story relating to Frank Sonier's case is quite authentic. He himself of course might have been mistaken. A number of singular instances could be recorded such as smoking the pipes of lepers, washing their clothes, &c.

It is impossible to account for the appearance of the disease at the same time in the three or four different families, already named on any other theory except that of contagion.

(1.) Peter Noel came from a healthy family so far as could be ascertained. He slept during the summer with a man in the advanced stages of leprosy and a few years afterwards became a victim to the disease. He is now a patient in the lazaretto.

(2.) James McGrath caught the disease from one Michael

REMARKS ON EXOPHTHALMIC GOITRE, HYGROMA AND ACUTE INFLAMMATION OF THE THYROID GLAND, WITH ILLUSTRATIVE CASES.

By GEO. W. MAJOR, B.A., M.D.,

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There exists an amount of vagueness as to the class of cases to which the term *Exophthalmic Goitre* should be applied. This, evidently, is the result of the many ways in which this condition presents itself, and the changeable character of the symptoms at different periods in the course of the disease. That the disease is not a *goitre* in the proper sense of the term is generally admitted in modern medical works; yet this malady is treated under the heading of *Bronchocele*, and to some extent seems to be regarded as an affection of the thyroid gland. This state of things is, to say the least, unfortunate, as it is liable to lead to error and misapprehension. It would have been almost better to have adhered to the old names—Basedow's or Graves' disease—rather than to have named it from its two most prominent symptoms. Goitre proper is either an hypertrophy of the gland tissue itself or the result of the development of cystomata in the glandular substance; whereas, in Basedow's or Graves' disease, the so-called goitre is an enlargement, not the result of increased glandular development, but of increased blood supply caused by dilatation of the arteries supplying the gland, and consequent venous engorgement. Later on, glandular hypertrophy may take place, as would happen in glands in any other region under similar circulatory conditions. So that, instead of regarding the local enlargement as merely symptomatic of a serious neurosis, it has come to be looked upon as part of a disease requiring medical treatment. Parts whose vascular supply is influenced by the cervical ganglia of the sympathetic are more or less involved in this plethora, and, as a result, we have exophthalmos, impairment of digestion, rapid and irritable heart, arterial dilatation, and hyperæmia of the mucous membrane lining nose, pharynx and

larynx, giving rise to a catarrhal discharge and dysphonia,—these latter valuable, as often the earliest symptoms, and most likely to attract attention to the large compressible and cushiony thyroid gland in its earliest stage of engorgement.

By many, exophthalmic goitre is held to be the result of anæmia. Anæmia may co-exist, perhaps as a result of the neurosis we are considering; possibly as an accidental concomitant, but more likely as a secondary affection to the impairment of the digestive functions. In the severe cases which have come under my notice, there was a condition opposed to anæmia—though impoverishment of the blood afterwards followed as the result of the constitutional dyscrasia. Three cases at present under observation certainly are in no way anæmic. Artificial irritation of the cervical has, experimentally, produced conditions resembling exophthalmic goitre. This fact alone should decide the nervous origin. The exophthalmos has been accounted for in a variety of ways, but the vascular is the most likely theory. Galvanization of the cervical-sympathetic and pneumogastric diminishes the protrusion, as also the enlargement of the thyroid and the rapidity of the heart's action—another point in favor of a central cause. I remember a case under Dr. Woakes, at the Hospital for Diseases of the Throat and Chest, London, in which hydrobromic acid gave good temporary results. The use of ergot and belladonna occasionally is followed by improvement, but galvanization, certainly, is most to be relied on.

In so far as my experience goes, the disease is a very unsatisfactory one to treat—the prognosis is not favorable. The reported cases of cures seem to me to be rather exaggerated, and lacking some of the elements of the disease as now understood. The varying rapidity with which these peculiar symptoms develop is well shown in the following clinical reports:—

Case I.—In Feb'y, 1883, X—, a married lady, and an accomplished vocalist, consulted me for loss of singing voice. Laryngoscopic examination revealed general hyperæmia, absence of swelling, and faulty approximation of the vocal bands. There was also a profuse nasal catarrh, and the Schneiderian membrane was acutely congested. The thyroid gland was tender to pressure, but no

great swelling was present; it was soft and compressible, and imparted, on gentle manipulation, a sensible thrill. The general health was much impaired; digestion was improperly performed, and there had been rapid loss of weight. No exophthalmos was noticed. The heart's action was rapid (120), and showed much irritability. Sleeplessness and despondency, alternating with hysterical buoyancy, were also complained of. Under a suitable medical and dietetic regimen, aided by sprays locally, improvement set in in the course of a couple of weeks. During the third week, and in a space of time not exceeding 24 hours, exophthalmos, almost amounting to dislocation, was developed. The appetite is good even to voracity, yet there is no gain in weight. The assignable cause was mental excitement, coupled with fatigue. The symptoms are subject to occasional remissions and exacerbations.

CASE II.—In November last, Mr. S—, aged 50, a London solicitor, of very close business habits, was enjoying a week's shooting in the Highlands; in order to rejoin his party, he was compelled, at the close of the day, to run, heavily weighted with gun and game, a distance of two miles. The same evening he found his heart very troublesome, and a peculiar sense of fullness over the thyroid region. He consulted Sir William Jenner ten days afterward, who remarked the prominence of his eyes, as also the tenderness and enlargement of the thyroid gland. Gradually dyspeptic symptoms showed themselves, and great loss of weight resulted. He was ordered to Canada for a change, annd referred to me by Dr. Clement Godson, of Grosvenor street. The sea voyage had agreed with him immensely, and all the troublesome head symptoms had disappeared, but returned upon landing. The appetite was voracious and digestion fairly good. The varying accommodation of vision was a source of great annoyance, as also the continuance of dizziness. I ordered for him digitalis and ergot, with the happiest result. So far the symptoms have been so controlled as to give comparative freedom from discomfort.

This case is interesting as showing the effect of great physical effort in producing a condition generally conceded to be the

result of mental or moral causes. The prominence of the eyes was very great and reached a maximum in less than ten days. The sea voyage proved beneficial as it also did in the foregoing case, and might prove a therapeutic measure of some value if sufficiently prolonged.

The third case at present under notice is not a typical one, but worthy of report, as showing the modification this disease may undergo, as also its occasional chronicity.

CASE III.—Z—, a young woman of 26 years, saw me in consultation at the instance of Dr. Reddy. The exopthalmos was not very marked, but the varying sight, even at the interval of a few minutes, was remarkable. At the age of 13, corresponding to first menstruation, the disease manifested itself, and has continued ever since, with catamenial aggravations. Head symptoms are particularly annoying at all times, but under the use of hydrobromic acid and galvanism relief amounting to almost entire freedom is obtained. Any mental excitement or bodily fatigue aggravates the disease, and the resulting prominence of the eyes, fullness of the throat and suffocative feeling, with salivation, are preceded by capillary congestion of the face and neck.

Acute Thyroid Cyst.—The bursæ of the thyro-hyoid region, of which there are three, occasionally take upon themselves inflammatory action, developing into cysts technically known as *Hygromata*. They vary much in size, and interfere proportionately with the healthy functions of the parts. They form, as a rule, slowly, but occasionally with great activity, and then require prompt surgical interference. Through the courtesy of Dr. Lapthorn Smith, I am enabled to report an interesting case in point:—

In consultation with Dr. Lapthorn Smith I saw P— L—, a laborer, aged 50 years, convalescing from broncho-pneumonia. Some days previously, on coughing, he had felt a sharp pain over the larynx; swelling had gradually advanced until, at the date of my visit, a large pyriform, fluctuating tumor occupied the seat of the thyroid cartilage. Swallowing even of liquids had been rendered impossible for the last 24 hours, while res-

piration was but slightly embarrassed. After making an exploratory puncture, the contents of the sac were allowed to escape, and fully four ounces of pus of a creamy consistence evacuated. After examining the wings of the thyroid with a probe to determine the presence of any diseased cartilage, the wound was treated antiseptically, and healed in a few days. Such a fortunate termination is not always secured, as troublesome fistulæ often remain, and necessitate extirpation of the bursa. In this case the Pomum Adami was largely developed, and probably accounts for the bursitis that resulted from the violent attacks of coughing.

Acute inflammation of the Thyroid Gland is a rare affection, and more likely to occur in a gland already enlarged than in one of normal proportions. The whole or only a portion of the gland may be involved, but usually the whole. It may result from mechanical injury, or from exposure to cold and inclement weather, especially when under poor hygienic conditions. It may undergo resolution or advance to suppuration. It may exert so great pressure posteriorly as to render deglutition impossible, or compress the laryngeal nerves to such an extent that life is imperilled. A brief report of a case recently under observation will best convey a correct idea of this condition :—

Joseph P—, a police constable, aged 47, a strong, muscular man, was admitted under Dr. Roddick into the surgical wards of the Montreal General Hospital, Feb. 28th, 1883, and referred to me for laryngoscopic examination. A week previously he had, when overheated, been exposed to sudden cold, and complained of some stiffness of the neck in consequence. The gland swelled and reached its maximum of development in six days. The neck presented a brawny, glossy look, and showed great distention of the fascia. The whole gland was inflamed, but the left lobe to a greater extent than the right. There was slight pitting on pressure, but *no pain*. Swallowing was fairly good ; breathing, difficult and stridulous. Externally, the larynx could be seen displaced somewhat to the right. On laryngoscopic examination there was general pharyngo-laryngeal congestion, with slight œdema. The larynx was displaced to the right and backwards,

and occupied an oblique position; the epiglottis was doubled on itself in its long diameter, with its base pulled to the right. The left vocal band was not visible; the right was intensely congested. The voice was much impaired, as approximation was impossible. Any exertion produced alarming dyspnœa, and, in consequence, the examination had to be conducted leisurely. After a week's residence, during which time fly blisters and linseed poultices were applied, he was discharged unimproved, and referred to my clinic. A dilute ointment of binioidide of mercury was ordered to be rubbed in daily, and muriate of ammonia for internal administration. A gradual improvement followed, and when last seen (August 12th) he was engaged at laboring work. The position of the larynx is markedly improved, but some displacement still exists. The right vocal band is paralyzed, owing more to the stretching of the nerve over the convex surface of the larynx than to any direct pressure. The glandular enlargement had diminished to almost its natural size. Swallowing of solids or liquids was not at any time very difficult, notwithstanding the fact that the epiglottis, from its distorted condition, could not possibly do duty as a valve. The same freedom from the accident of food entering the larynx is frequently seen in syphilitic cases, when that valve is either partially or wholly destroyed. In such cases the larynx is drawn well up under the tongue, and the food or drink thrown further back by the tongue than would be required in a healthy state. The *freedom from pain is a noteworthy point*, and one of value in diagnosis when the question of *angina Ludovici* is at issue.

TWO CASES IN OBSTETRICAL PRACTICE.

By J. CAMPBELL, M.D.C.M., and L.R.C.P., Edin.

(Written for the Canada Medical Association.)

Mr. President and Gentlemen,—While we hear a good deal about successful cases of various kinds, it is but seldom that our unsuccessful cases are brought prominently forward. A general always likes to dwell upon his victories, and try, if possible, to forget his defeats; but by thoughtfully studying out the causes of our reverses, we may be able to achieve victory in the future.

It is with this object in view that I present for your consideration notes of two fatal cases in my midwifery practice.

CASE I.—On the morning of the 8th of June, 1873, I was called to attend Mrs. C., aged 30, in her second confinement. I had, besides the confinement mentioned, also attended her in typhoid fever, complicated with a miscarriage, when she recovered, contrary to my expectations. When I arrived, I made an examination, and found that the os would hardly admit the index finger, and the pains were not by any means strong. Having been out of bed all night, I lay down on a sofa in the adjoining room, leaving the patient in charge of an experienced midwife, the husband in the meantime having left for the purpose of bringing friends who were distant seven miles. Within ten minutes I sank into a sound sleep, when I was suddenly awakened by a loud, shrill scream. I sprang to the bedside and found that the child was born. Remembering that she had flooded freely at the previous confinement, I immediately seized the uterus, which I found contracted and about the size of a fœtal head, the one strong pain having expelled the child and placenta together. While I was thus engaged the woman called for air and said she was choking, referring her distress to the precordial region. The face was cyanotic, and there was intense dyspnœa almost amounting to orthopnœa. I ordered the attendant to raise the window and give brandy, while a messenger was despatched for the nearest medical man. The surface became cold and clammy, the pulse weak, rapid, small and fluttering, until it left the wrist entirely; the heart's action was tumultuous. The patient was gasping for breath; big, round drops of perspiration were standing like beads on her livid forehead. She tossed her arms to and fro, the gasping became weaker and weaker, with longer intervals between, the muscular system gradually became relaxed, and, with a long drawn sigh, the vital spark departed. This all took place within the short space of five minutes. I still had control of the womb when the other doctor entered, and I drew his attention and that of the midwife to the fact. It only relaxed under the powerful hand of death. I also drew the doctor's attention to the bed and the

chamber to satisfy him that there was no flooding. I mention these things particularly, from the fact that the same medical man told his own and deceased's friends afterwards that the woman had died from flooding, and that he "could have taken hold of that womb and pumped a pailful of blood out of it." I was a young practitioner then, staking my all upon success. I felt that I had sustained a Waterloo defeat. I reached my office with a sad heart. I found there Dr. Stewart, of Brucefield, now of Montreal, waiting for me. I related to him the history of the case, and we talked over the matter in a familiar manner, and arrived at the conclusion that death had resulted from an embolism, which had occluded either the main trunk or a large branch of the pulmonary artery, and that no human skill could have averted the sad catastrophe which had just taken place. This was a great relief to my mind, so, with *resurgam* for my motto, I started forth afresh in my obstetrical practice.

CASE II.—I was called to see Mrs. B. early on the morning of March 19th, of the present year. Found her in labor of her sixth child. Her age was 38 years. She was the wife of a mechanic. The labor was a natural one. In a few hours she was delivered of a healthy boy. The woman was rather lean and pale, and of a despondent nature. The placenta was expelled naturally. We had the clothing changed on the spot, so that nothing soiled remained. She had neither nurse nor servant, her attendants being her husband and a rather careless daughter of 12 years. A neighboring woman visited her occasionally. I saw her upon the 20th, 21st and 22nd, and found the temperature normal and the patient doing as well as could be expected, considering that she had to take care of her child, and that she had very little help in the way of changing the soiled clothing, which I insisted should be changed every morning for three or four days at least.

I did not see her on the 23rd, as I had discontinued my attendance. On the morning of the 24th I was called in, and upon inquiry found that she had been taken with chills early on the previous night, followed by a burning sensation and pain over the uterus. She persuaded her husband to apply snow to the

part during the night, which she said had relieved her. The temperature was 103° ; pulse 130 ; the lochia suppressed. We looked upon it as a case of septicæmia, and treated it accordingly. We washed out the womb every four or five hours with carbolic acid lotion, gave large doses of quinine at short intervals, applied hot fomentations to the abdomen, changed the clothing frequently, ordered fresh air and liquid nourishment, with a fair amount of stimulation, quieted the system and relieved pain with opium, and, later on, with chloral hydrate when sleeplessness became a prominent symptom. Under this treatment the temperature gradually came down, the pulse got slower and stronger; until, on the morning of the 26th, the fever had entirely subsided, and we considered our patient out of danger from septic poisoning. The milk, which had been secreted moderately before her sickness began, did not return, and the pulse still remained somewhat rapid. The lochia had returned. The patient was, as usual, downhearted. On the evening of the 26th, I was called in great haste, and found her flooding to a dangerous extent. Felt certain that she could not last long unless the hemorrhage was stopped, and thinking it a good case for hot water injections, I used them immediately, passing the vaginal tube well up, and using the water almost hot enough to burn my hands. At the same time I gave ergot and sent for an assistant, but had the hemorrhage stopped before his arrival. This was the first time I had occasion to use hot water injections, which I had heard so strongly recommended by obstetrical teachers in Edinburgh, and I had no reason to be dissatisfied with the result. As the flooding did not return, we thought we had our patient once more. We continued giving ergot at intervals, and held ourselves in readiness for any emergency. On the morning of the 27th, when I visited my patient, was astonished to find that she had pain, which was referred to the left lung, near the nipple, accompanied with a cough and elevation of temperature. She had had a rigor during the night. Upon examination, found well marked symptoms of pneumonia of the left lung. During the day rusty expectoration set in, the sputa being of the prune-juice variety. Feeling confident that our patient must succumb,

we asked for a consultation, which took place, and we assured the husband that it was only a matter of time—his wife must go. We did not relax treatment, however, and gave liquid nourishment and stimulants without stint both per orem and per rectum. She died on the 30th, exactly eleven days from the date of confinement.

REMARKS.

The points of interest in this case are the following :—

1st. The occurrence of so-called puerperal fever without any known cause, this being the only case of the kind in my practice, and I always wash my hands in carbolic lotion and use carbolic oil when making examinations in such cases.

2nd. The next point is the occurrence of secondary hemorrhage on the seventh day after delivery, which promptly yielded to hot water injections.

3rd, The third and most important point is the attack of so-called pneumonia on the eighth day, resulting in death four days later. Was this really pleuro-pneumonia as we understand that disease? It certainly had all the characteristics of an orthodox attack.

We believe, however, that the cause of the pneumonic symptoms in question, was embolism. Here we had, to begin with, the highly fibrinated condition of the blood, natural to puerperal women, and this condition still further intensified by an exhausting hæmorrhage, rendering the formation of a thrombus and subsequently the occurrence of an embolism, highly probable. It has been shewn upon good authority that attacks of so-called pneumonia when they occur in the course of phlegmasia dolens are usually due to hæmorrhagic infarctions caused by the transmission of a clot or clots from the veins, to the right side of the heart and thence to the pulmonary artery.

It has also been proved by post mortem examinations, microscopic ond otherwise, that embolic infarctions in the lungs and other organs, follow fractures, then why not in the present case, where the conditions were so very favorable?

Valvular disease of the heart as one of the causes of emboli, could be eliminated in our case, as there was no heart disease.

An autopsy, which, however, could not be obtained, would have settled this important point.

Reviews and Notices of Books.

A Treatise on Insanity in its Medical Relations.—By Wm. A. Hammond, M.D., Surgeon-General U. S. Army (retired list), Professor of Diseases of the Mind and Nervous System in the New York Post-Graduate Medical School; President of the American Neurological Society, etc. New York: D. Appleton & Co. Montreal: Dawson Bros.

Prof. Hammond, not having been himself a specialist devoted exclusively to the study of mental alienation as superintendent of a Lunatic Asylum, it might surprise some that he should appear as a writer on this subject. He recognizes this fact and alludes to it in his preface to the present work. But, at the same time, he is well-known as having for many years devoted his entire energies to the careful examination of all the pathological phenomena connected with affections of the nervous system. He has also been a teacher of mental diseases in the largest schools of New York City. Although, therefore, many men may have acquired more extensive experience in cases of mental disorder, yet his own observations must have been very numerous, and the careful study which one of his ability is capable of giving them, render his opinions upon this difficult subject well worthy of careful consideration. The first section is devoted to a consideration of the Physiology and Pathology of the Human Mind. The second treats of Instinct, its nature and seat. The third, a very valuable one, explains the phenomena of Sleep. The author says, and doubtless has good grounds for the remark, "I think that a knowledge of the physiology and pathology of this function should form the groundwork of the study of insanity. It is in aberrations of sleep that we often find the first indications of aberrations of mind." Section IV. gives the description and treatment of the various forms of insanity. It is admitted that, as yet, no true classification, based on anatomical and pathological data can be made, but it is thought that the condition of central blood-supply is that which must be looked to, to furnish these desirable facts.

"There are indications that vaso-motor disturbances, by which the amount of intracranial blood is altered, either by increase or diminution, is the starting-point at least of almost every known form of mental derangement." We have not space to enter more fully into the merits of this new treatise, but we may say that it will be found to contain a complete description of almost all the varieties of mental disease, illustrated by numerous examples taken from the author's *clientèle*. It is written in the forcible style for which Dr. Hammond is well known, and forms one of the best modern text-books on the subject which we know of.

Medical Essays. 1842—1882.—By OLIVER WENDELL HOLMES. Boston: Houghton, Mifflin & Co.

We take credit to ourselves for being able to say that, before receiving this volume, we had read almost all the essays it contains, for no one ever read the writings of the "Autocrat of the breakfast-table" without being instructed, refreshed, and delighted. It was specially appropriate that this year should have seen the issue of a new edition of these popular essays, for it is the year in which Dr. Wendell Holmes retired from the chair of Anatomy at Harvard, of which University he had so long been a distinguished ornament. The separate parts are arranged in the chronological order in which they appeared from his pen. Perhaps the best known of them are those entitled, "Homœopathy and its Kindred Delusions" and "Currents and Counter-currents in Medical Science." The exposure of Homœopathy, as it was one of the earliest, remains one of the most complete demonstrations yet given of the utter fallaciousness of the so-called system. The "Currents and Counter-currents" is full of the philosophy of this chief of our philosophers and bears reading time and again. His remarks upon "Bedside Teaching" on "The Young Practitioner" and on "Some of my Early Teachers," contains abundant food for thought. They are all written in that bright and sparkling style which is peculiarly his own and which gives such a charm to all he says. To those who may not have read these essays, we would say,

lose no time in doing so; to those who may have already perused them, we would likewise say, by all means get this handsome new edition containing the complete collection and read them again. For it is a handsome edition, as none know better than these Boston pnblishers how to present such books in their most attractive style.

The Microscope and its Revelations.—By WILLIAM B. CARPENTER, C.B., M.D., LL.D., F.R.S., Corresponding Member of the Institute of France and of the American Philosophical Society. Sixth edition. Illustrated by 26 plates and 500 wood engravings. Vols. I. & II. New York: Wm. Wood & Co.

This admirable work is reproduced in two volumes, as a part of the new series of Wood's Library for this year. In addition to the original treatise, everything that is new or worthy of note has been added. It will thus be found now, as ever, a complete guide to the efficient use of the microscope, and the exponent of the wonderful discoveries made with it of late years.

Books and Pamphlets Received.

WHAT TO DO FIRST IN ACCIDENTS AND EMERGENCIES. A Manual explaining the Treatment of Surgical and other Injuries in the absence of the Physician. By Charles W. Dalles, M.D. Second edition, revised and enlarged, with new illustrations. Philadelphia: P. Blakiston, Son & Co.

THE ROLLER BANDAGE. By William B. Hopkins, M.D. With 73 illustrations. Philadelphia: J. B. Lippincott & Co.

GOUT IN ITS PROTEAN ASPECTS. By J. Milner Fothergill, M.D. Detroit, Mich.: Geo. S. Davis.

A TEXT-BOOK OF GENERAL PATHOLOGICAL ANATOMY AND PATHOGENESIS. By Ernest Ziegler. Translated and edited for English students by Donald McAlister, M.A., M.B. New York: Wm. Wood & Co.

ELEMENTS OF HISTOLOGY. By E. Klein, M.D., F.R.S. Illustrated with 181 engravings. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Bros.

THE MEDICAL STUDENT'S MANUAL OF CHEMISTRY. By R. A. Witthaus, A.M., M.D. New York: Wm. Wood & Co.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, July 6th, 1883.

THE PRESIDENT, DR. KENNEDY, IN THE CHAIR.

Dr. Trenholme exhibited two pairs of *Ovaries and Fallopian Tubes* removed from patients in St. Catharines. All the ovaries were diseased, being several times larger than normal, the hypertrophy and induration due to dense fibroid tissue. The tubes were intensely congested at the time of removal. The indications for the operation in each case were intense pelvic suffering, in one case dysmenorrhœa with menorrhagia and in both oöphoralgia with all their accompanying general nervous derangement. In both cases the operation was made with antiseptic precaution, but without spray, and both made a good recovery, though in one case from fifteen years of suffering, convalescence was slow. Dr. Trenholme stated that the case operated on some three months ago was doing well, being free from all those pelvic pains for which the operation was made and able to perform household duties, though previously an invalid for many years.

Dr. Gardner also shewed a pair of ovaries which he had removed eight days before. The patient, 38 years of age, had suffered from dysmenorrhœa for several years. She consulted Dr. Thomas, of New York, same months ago and he prescribed for her anteflexion, replacement twice a week, hot douche twice a day, galvanism over ovaries, and arsenic internally. This treatment was carried out by Dr. Gardner for some time, he also tried galvanic and other stem pessaries, and dilated with tents with but little or no good results. Patient was an invalid going from bed to sofa and on motion, or pressure on abdomen suffered from paroxysmal pains in iliac region. She was very anxious to be operated on. Dr. Gardner performed the operation under the spray, applying a double ligature and removing both ovaries and fallopian tubes. Patient recovered completely without a bad system; highest temperature, 100½° To-day there was a slight thrombus of the vein of left leg. Calf, behind knee and thigh, very tender. The ovaries were

both diseased, one having a cyst the size of a pigeon's egg, the other indurated masses in its tissue, tubes somewhat dilated.

Dr. GARDNER mentioned that in the case brought before the society at last meeting, when he had operated five weeks ago, his patient had the usual metrostaxis for a few days, but has lost nothing since. The uterus has undergone involution to half its previous volume. Her complexion, which was bronzed, is much clearer. Has a purulent catarrh of the bladder and lithuria; otherwise is somewhat better.

Dr. OSLER said he had often met, post mortem, with ovaries and tubes as badly diseased, yet without history of pain during menstruation.

Dr. GARDNER said why sometimes painful, is probably that, when diseased, it aggravates an innate vice. Condition of celibacy producing a want (only satisfied by a happy married life) may be one factor in production of this tronble. He believed the last case of his would have been benefited by Dr. Weir Mitchell's treatment, but the means were not available for sending her to Philadelphia, and we were not yet prepared to carry out this treatment fully in Montreal.

Dr. Gardner next exhibited a *Mucous Fibroid* the size of a turkey's egg removed by him from a woman, aged 44 years, the mother of several children, the last four and a half years ago, and had no health since. Greatly weakened by profuse menstruation, was blanched and suffered from nausea at each period. When seen by Dr. Gardner uterus was so enlarged as to half fill the pelvis. Dilated with tents, felt tumor with finger, but could not well make out a pedicle. In waiting for the next period it was found that the dilating had delayed it. Instead of 21 days it was 40, and only lasted three days and there was less nausea. Dilated again and under ether removed it without much difficulty by means of Thomas' serrated scoop, was attached to the left lateral wall and fundus. Daily irrigation of uterus with a double tube was kept up for some time, a little iodoform was also put into the uterus each time. Patient recovered completely; had no pain and no offensive odor.

Contagious Syphilitic Lesions of the Os and Cervix Uteri.—Dr. Bell read a paper on this subject, based on the reports of three cases of what had been diagnosed as simple ulceration or erosion of the os uteri in young prostitutes, in whom no other possible source of syphilitic inoculation could be found, but to whom several cases of syphilis were distinctly traceable. Three cases were traced to the first patient, two to the second, and two to the third. In the first case, the disease was communicated shortly before the patient was admitted to hospital. In the second case, it was communicated within fifteen days after the patient had left the hospital; and in the third case, a considerable period of time had elapsed. Brief reports of these cases were given, and the writer expressed his opinion that in the first two cases the sores were uterine chancres, though not diagnosed as such at the time; while in the third case, the report of which was meagre and imperfect, he thought it probable that syphilis had been engrafted upon the simple erosion of the os subsequent to her residence in the hospital. The first patient passed from observation completely on leaving the hospital; the second was under partial observation for nearly a year without the appearance of any definite secondary lesion; and the third developed secondary symptoms about three months after leaving hospital. The writer excepted the cases contracted from the third patient from the discussion, as a period of eight months must have elapsed from the time she was under observation before their inoculation could have occurred. He also drew attention, in the other five cases (which were considered reliable), to the mild character of the disease throughout, and especially to the uncertain and atypical characters of the primary sore, and expressed the opinion that, owing to the great frequency of the occurrence of simple erosions of the os uteri, many infecting syphilitic sores were probably overlooked, and that in this way might be explained many of the obscure cases of syphilis in which no history could be obtained of primary sore.

Dr. Roddick said he saw one of the parties who contracted syphilis from Dr. Bell's third case. He (Dr. R.) believed this one, as well as the other two, must have had mucous patches of the os, which must have been there for a long time, preceded

probably by chancres of the vulva. Dr. Roddick's patient had a doubtful chancre, not hard; came on fourteen days after connection. He put him on constitutional treatment at once, and thought this should be done in every case where one is pretty sure chancre exists. Don't wait for "secondaries"; give Iodide of Mercury or Hyd. with Creta. His patient is now having slight secondary symptoms. A friend of his contracting from the same woman and keeping it a secret, is having a sharp attack of secondaries.

DR. GARDNER said that out of three or four thousand uterine examinations, only saw one undoubted case of chancre of the os, and there were also ulcers on the vulva.

DR. SHEPHERD thought syphilis was often implanted on an erosion of the os, and overlooked; believed in waiting for secondary symptoms before treating, as treatment sometimes delays the skin eruptions. Had had a case of squamous syphilide without any sore whatever. which disappeared under constitutional treatment.

DR. HINGSTON said most surgeons used mercury for syphilis. Now, he never uses it; his treatment being, to support strength with good diet, cleanliness, gives Iodide of Potassium, Nitric and Hydrochloric Acids, and some bitter tonic. He said the Indian surgeons found they had as good success without, as with, mercury.

DR. RODDICK said he used to wait for secondary symptoms, but experience had taught him to treat undoubted cases at once. Has never yet seen or known secondary lesions delayed; always come on in two months, are always modified, never saw bad lesions if so treated; found they got over quickly, and had slight, or never any, tertiary.

DR. GARDNER said an argument for waiting for secondaries would be where there was a question of marriage.

DR. F. W. CAMPBELL spoke against the press publishing "fearful operations" together with name of operators. He read from a recent number of the *Star*, an account of an operation which had been performed at one of our city hospitals, showing technical terms used correctly, indicating that some medical man must have furnished the item.

Several members suggested remedies for this state of things, and from them it was traced to medical students, who were also

reporters. The Council was asked to draw up a petition to be sent to the editors of the various papers, asking them to refrain in future from publishing such articles.

CANADA MEDICAL ASSOCIATION.

THIRD DAY, SEPT. 7.

[This portion of the proceedings was inavoidably excluded from our last issue.—ED.]

The Association met at 10 a.m., the President in the chair.

DR. BOTSFORD presented the report of the Nominating Committee for the election of officers, which was as follows:—

President, Dr. Sullivan, of Kingston. *Vice-Presidents* for Ontario, Dr. Thorburn; Quebec, Dr. Robillard; New Brunswick, Dr. James Christie; Nova Scotia, Dr. McDonald; Manitoba, Dr. Lynch. *General Secretary*, Dr. Osler, of Montreal. *Treasurer*, Dr. Spragge, of Toronto. *Local Secretaries* for Ontario, Dr. Bray, Chatham; Quebec, Dr. James Bell, Montreal; New Brunswick, Dr. Coleman, St. John; Nova Scotia, Dr. Black, Jr., Halifax; Manitoba, Dr. Betts, Winnipeg.

Montreal is to be the next place of meeting, the date to be fixed by the President and Secretary, and to arrange for the meeting to be held immediately before the meeting of the British Association for the Advancement of Science.

MEMBERS OF COMMITTEES.

Committee of Management.—Drs. Hingston, F. W. Campbell, George Ross, Roddick, Lachapelle, Gardner and Rodger, with power to add to their number.

Publication.—Drs. Ross, Cameron, Fulton and Sheard.

Medicine.—Drs. Graham, Toronto; Ross, Montreal; Oliver, Kingston.

Surgery.—Drs. Roddick, Montreal; Atherton, New Brunswick, and Tye, Chatham.

Obstetrics.—Drs. M. Lavell, Holmes, and Lawson (Halifax).

Therapeutics.—Drs. Wright, Toronto; Stewart, Montreal; Small, Ottawa.

Necrology.—Drs. Fulton and Wright, Toronto; J. C. Cameron, Montreal.

Education.—Drs. Cameron, Bray, Yeomans, Bayard (St. John), Parker (Halifax), Whiteford (Winnipeg), Wilkins (Montreal).

Public Health.—Drs. Canniff, Oldright, Robillard (Montreal), Yeomans, Harding, Worthington (St. John), Larocque, Botsford, Playter, Wickwire, Covernton, Bryce.

Ethics.—Drs. Mullin, Harrison, McCammon, Bray, Grant, Prevost, Osler, Almon, Coleman.

Delegates to American Medical Association.—Drs. Grant, Ottawa; Gardner and Hingston, Montreal. The President and Secretary to give credentials to others who may wish them.

Delegates to the American Public Health Association.—Drs. Larocque, Tye, Bray, Holmes, Sweetland and Covernton.

The report was unanimously adopted.

Unanimous votes of thanks were passed to the authorities of Queen's College; to the local doctors, for the cordial words of Dr. Sullivan; to the Mayor, for the freedom of the city.

CANADA

Medical and Surgical Journal.

MONTREAL, OCTOBER, 1883.

THE QUEBEC MEETING.

A report of the first meeting of the new Provincial Medical Board will be found on another page. The subject of the preliminary examinations received considerable attention. Dr. Lachapelle in introducing his motion with reference to this matter, alluded to the very large proportion of failures on the part of candidates at this examination. The present year has been no exception to the general rule, nineteen candidates only having passed out of forty-seven. It would seem from this that the training of those presenting themselves must have been deficient; at any rate they have not come up to what by the examiners is considered a very moderate standard. At the same time it was thought that a conference between the examiners, certain members of the Board, and the heads of teaching establishments in the Province, might be useful in the way of furthering a common understanding as to the exact extent and character of the examination required. The promoters of this move disclaimed any desire to have the standard of the examination in any way lowered, their object being rather to impress upon teachers the requirements of the examiners and thus induce them to bring forward their pupils in a better state of preparation. With this understanding the committee was named, and it is to be hoped that good may come from this work and that in future years, with a similar examination, a much larger proportion of candidates may prove successful.

As this was the first meeting of a new Board it may not be out of place to make a few remarks upon the manner in which the business of this influential body is transacted. The Pro-

vincial Medical Board has several functions of an important nature to perform. It is the Registering or Licensing body and it is also, in some cases, an Examining body. In registering applicants presenting what purport to be the qualifications necessary for the license to practice, it is right that every care should be exercised, and in every case involving the slightest doubt, the matter should be submitted to the entire Board for their judgment thereon. The verdict may be one of great moment. It results either in pronouncing the applicant legally fitted and qualified for the exercise of his profession or refusing him this valuable privilege. Too much care cannot be exercised in scrutinizing and considering individual claims. It is well known that through want of vigilance in past years names have been entered upon our Provincial Register which should never have been there. Once put a name on the official list, and probably felony alone will cause it be removed. All sorts of irregular practices may be indulged in, notorious and glaringly unprofessional proceedings may be persistently carried on, and yet the act of Registration will not be revoked. Hence it is that such watchful scrutiny should be observed in looking carefully and strictly into the credentials which are laid before the Board by license-candidates. The manner in which this is done at present is as follows: A committee is named to examine the qualifications and report to the meeting thereon. Now, this having been done, nine members are appointed to act as examiners of candidates without University or other credentials entitling them to dispense with this ordeal. The examiners proceed with their duties in another apartment, the general meeting meanwhile proceeding. When they have concluded their examination and return to the meeting, it is only to find that the report of the scrutineers has been presented, a final vote of thanks for the use of the Hall is passed, and the meeting is adjourned. We must say, in our opinion, this is most unbusiness-like. Nine members from a small Board are absent, whilst the remainder pass upon the report of the scrutinizing committee and transact any other business that may be brought before them. Thus a large minority of the Board are excluded

from participation in more than one-half of the meeting, This clearly should not be. All the members of the Board should be present during the transaction of business, and arrangements should be made for the carrying on of the examinations in a way that would not interfere with this. Probably the chief reason why an abuse of this kind has been allowed to become habitual is, that the time allowed for the sitting of the Board is entirely too short to put through, with any kind of regularity or decorum the business brought before it. One day—and a very short day at that (10.30 a.m. to 4.30 p.m., with an hour's intermission)—is not enough. The Board now sits *twice* a year. We think if one session of two days *once* in the year were to be the rule, and if proper arrangements were made *beforehand* for the examination of candidates, that the efficiency of the Board would be greatly increased and its business could be conducted with a becoming calmness and dignity and not rushed through with railroad speed as is now the case. We hope these considerations may receive the attention of the President and members, as we are by no means alone in the views we have expressed above.

"L'ECOLE DE MEDECINE ET DE CHIRURGIE."

In August last we wrote with reference to the Laval-Victoria contention, "causa finita est." The recognized head of the Catholic Church had, after long consideration, pronounced adversely to the old school, which had been definitely ordered to discontinue, on pain of the most severe ecclesiastical displeasure. But we were hasty in having so written, the cause was *not* finished—far from it. Within a very few weeks from the promulgation of the Bishop's *mandement* enforcing the Pope's decree, messages from Rome announced that the decision was reversed—that the Professors of the *école* might continue to teach Anatomy and Physiology without finding themselves outside the pale of the church, and that students might learn the same subjects from their instructors without that step leading to their everlasting condemnation. The *école* now enjoys the unique privilege of announcing in its prospectus for the

year that it re-opens "by the express and paternal desire of the Holy Father." What powerful agency has been influential in thus entirely changing the respective attitudes of the two schools? The answer to this must be found in the potent words, *civil rights*. The old school had civil rights, and it has already been decided by the highest court in the Empire that these shall not be superseded by any ecclesiastical authority. Many in Montreal will remember how the entire local militia was paraded to enforce the burial of Guibord. It would have led to unpleasantness had similar measures been required to force an entry into the Hotel Dieu or otherwise protect the privileges of an old and legally-established corporation. The lesson then taught has been well learned.

THE PROVINCIAL MEDICAL BOARD.

The semi-annual meeting of the Medical Board of the Province of Quebec was held in the city of Quebec, on Monday, 26th ult. The following members were present:—Dr. C. E. Lemieux, President; Hon. Dr. J. J. Ross, Vice President; Drs. A. G. Belleau and F. W. Campbell, Secretaries; Dr. E. P. Lachapelle, Treasurer; Dr. Larue, Registrar. Hon. Dr. Robitaille (Lt.-Governor), Drs. Joseph Lanctôt, J. A. Duchesneau, R. A. Kennedy, D. A. Hart, Malcolm Guay, W. Marsden, Charles Gingras, R. P. Howard, J. L. Leprohon, T. A. Rodger, Geo. Ross, H. A. Mignault, P. E. Grandbois, Jos. Marmette, L. D. Lafontaine, N. H. Ladouceur, C. S. Parke, E. A. de St. George, Henry Russell, L. T. E. Rousseau.

The minutes of the last half-yearly meeting, 9th May, and of the triennial meeting of the 11th July last, were read and approved.

It was moved by Dr. Lafontaine, seconded by Dr. Howard, and resolved, "That the members of the Provincial Medical Board have learned with much regret of the death of the lamented Dr. Ed. Laberge, of Ste. Philomene, a member of the Legislative Assembly of the Province of Quebec, and formerly a governor of the College of Physicians and Surgeons of this Province; that the members of this Board desire to express

fessors and students of this school to meet again. Dr. D'Orsonnens, the President, delivered a stirring address, in which he said: "This meeting of the Montreal School of Medicine is, certainly, its most glorious day, for the School, threatened in its very existence—nay, thunderstruck, I should rather say—but a few weeks ago, and apparently lost forever in the eyes of every one, is seen again by its friends, in this the opening day of its lectures, more renowned and more brilliant than ever, and with a still greater guarantee of success for the future than before. It is, then, with the greatest joy that the school opens for you its doors, for it can no more be represented to the public, unaware of all that took place, as in rebellion against the Holy See, the school being now about to resume its teaching on the formal order of His Holiness Leo XIII. Moreover, the sending from Rome of an apostolic delegate to Canada is, for the school, a sure guarantee of a still more perfect reestablishment, and the proof that it will be forever now, even in the eyes of ecclesiastical authority, established on a solid and immovable basis. How many ill-feelings disappear, and how many scandals are arrested, by this energetic action of our Holy Father! and how happy you Christian families must have felt upon hearing the good news. Thanks, then, to the Sovereign Pontiff, who kindly listened to our cry of distress, and replied in a manner so prompt and so paternal."

Bishop's College and Laval (Montreal Branch).—The classes reassembled on the 2nd inst. There were no special introductory addresses.

College of Pharmacy.—This College opened on the 2nd inst., in new rooms, at 223 McGill Street. A large number of students have entered, and a successful season is anticipated.

Toronto School.—Dr. J. H. Richardson delivered the opening lecture in the presence of the Mayor and a large gathering of students and citizens. He urged upon the authorities of the university to establish a chair of Physiology and a suitable laboratory as it is impossible for schools of medicine, dependent

solely on the fees of students, to spend the money necessary for teaching the purely scientific branches.

TRINITY SCHOOL.—Dr. Sheard gave the introductory address in the presence of the Faculty and a large gathering of citizens and students.

KINGSTON WOMEN'S MEDICAL COLLEGE.—The co-education troubles of last winter have resulted in the establishment of a separate school of medicine for women in Kingston, which, on the 2nd, was formally opened by the President, Dr. Lavell. $7,500 have been subscribed, sufficient working expenses for five years. Three scholarships have been founded, one by Mrs. Dr. Trout, of Toronto, one by Mrs. McNeill, of Kingston, and a third by the ladies of Kingston. The old students have returned and new ones are expected. The Faculty is composed entirely of the Professors in the College of Physicians and Surgeons who will repeat their lectures to the ladies.

TORONTO WOMEN'S MEDICAL COLLEGE was opened by Dr. Barrett, the President, in the presence of the Mayor and a large gathering of ladies and gentleman. Speeches were delivered by the Mayor, Mr. Beatty, M.P., Principal Caven, and Mrs. McEwen. Subscriptions to the amount of $1,200 have been promised and a suitable building has been secured. The hospital authorities have arranged a special place in the theatre for the women and every facility will be afforded them. A large class is anticipated.

WESTERN UNIVERSITY, LONDON, ONT.—The second session of the Medical Faculty was opened on the 1st with an introductory address by Dr. Bucke of the London Asylum, who spoke in hopeful terms of the prospects of the school.

STILL ANOTHER.—A meeting of the Winnipeg medical profession was held in the Education offices recently for the purpose of taking steps towards the formation of a medical college there. The following charter members were appointed, with

instructions to submit a bill of incorporation to the Provincial Legislature :—Drs. Kerr, Jones, Brett, Whiteford, Good, Patterson, Blanchard, A. A. Ferguson, R. B. Ferguson, Sutherland, Codd, Wilson.

PRELIMINARY EXAMINATIONS.—The matriculation examination of the Provincial Medical Board was held at Quebec from the 20th to the 22nd September. Forty-seven candidates went up, of these nineteen were successful. The names of the latter were as follows: Kenneth Cameron, Montreal; L. Jos. Sirois, Bic; P. Marchildon, St. Justin; Edward L. Quirk, Alymer; Dos. Fournier, St.-Simon de Rimouski; Vilda J. Groulx, Belle Riviere; Rollo Campbell, Montreal; J. Alb. Marcotte, Ste Monique de Nicolet; H. Desilets, Bécancourt; Chas F. Carle, Ste-Ursule; S J Girard, St. Germain; P J L Bissonette et J. A. Dagnault, St. Jacques le Mineur; Joseph F. E. Ferland, Lanoraie; Nas Gingras, St. Nicolas; E. A. Laferrière, Ste Cuthbert; Cyprier Rioux, Trois-Pistoles; Alf. Duhamel, St. Justin; G. Tremblay Belanger, Quebec.

THE ILLINOIS STATE BOARD OF HEALTH has issued a very complete report on "Medical Education and the Regulation of the Practice of Medicine in the United States and Canada," giving a compendium of the laws regulating admission in each State and Province, and a statement regarding each medical school. Under "Canada," the Medical Acts of the various Provinces are given, a list of the schools, with number of students, percentage of graduates, fees, &c. The Toronto Woman's Medical College is erroneously stated to be homœopathic. An interesting summary is given, from which we gather that there are at present 89 regular medical schools in the United States and 12 in Canada; 48 colleges have become extinct. In the session of 1882-83, there were 9,764 students in the regular colleges in the States and 648 in Canada. The average percentage of graduates to matriculates is—in the United States, 33.2; in Canada, 25.4. There are 3,487 physicians in Canada, the ratio population being 1 to 1,112. New Mexico, South Carolina and Utah are the only States in which the ratio of

physicians to the population is above 1 to 1,000. Maryland and Colorado are the most over-doctored States; the proportion in the former is 1 to 329, and in the latter 1 to 341. A list of twenty-four institutions is given where diplomas are not recognized by the Board, and a number of others, concerning the "good standing" of which the Board has not yet decided.

QUADRUPLETS.—Drs. Edwards and McTaggart, of London, Ont., report a remarkable case. A woman, already the mother of four children, had what was supposed to be an early miscarriage in the last week of January, '83. Her abdomen continued to enlarge, and finally became of an immense size. On September 14th, 1883, she was confined of *four* living children, two boys and two girls, the time elapsing between the birth of the first and that of the last child being one hour and forty-five minutes. Three of the children weighed somewhat over four pounds, and one slightly under that weight. There was only one placenta. At last report all were alive and doing well.

M. SOUVIELLE.—We have been shown a letter from Prof. Rosenthal, of Erlangen, in which full details are given of the attempt by this man to obtain the degree of that University by presenting a forged thesis. Fortunately, the gentleman into whose hands it was placed for criticism recognized the production as spurious, and the fraud was detected. The worst feature of the case is that M. Souvielle passed himself off as a Canadian and a Montrealer, and has, by his disgraceful action, smirched the fair name of both the country and the city.

THE HOMEWOOD RETREAT.—This private asylum at Guelph, Ont., will be opened for the reception of the insane and inebriates next month, with accommodation for fifty patients. Dr. Lett, for thirteen years assistant superintendent of Ontario public asylums, will have charge. Mr. Langmuir, so long Inspector of Asylums in that Province, is President of the Association. From our personal knowledge of these gentlemen we can heartily recommend the Retreat to the support of the Profession.

Obituary.

JAMES A. SEWELL, M.D., EDIN.

The death of this well-known physician of Quebec took place at his residence, St. Ursule Street, on the 2nd inst. Dr. Sewell was born in Quebec in 1810, and was a son of the late Chief-Justice Sewell. After receiving his professional education in Edinburgh, where he graduated in 1833, he settled in his native town, and had there been engaged in active practice to within a few months of his death. He was one of the original members of the Faculty of Medicine of Laval University, and held the chair of Medicine, and was also Dean of the School. He was chairman of the Marine Hospital Commission, and one of the physicians to the Hotel Dieu. As a governor of the College of Physicians and Surgeons, he took an active part for many years in all the affairs of the Board. At the organization of the Canada Medical Association in 1867, Dr. Sewell was President of the Quebec Medical Society, and took the chair on the first day of the meeting. Subsequently, in the year 1871, he was elected President of the Association. For many years Dr. Sewell was a constant contributor to the *British-American Journal* and the *Canada Medical Journal*, in the files of which many of his interesting cases and communications will be found. He was an ardent advocate for the use of tea as a stimulant, and as an antidote to the effects of opium and in uræmia.

Dr. Sewell was twice married, and leaves a large family. Two sons are in the profession, both graduates of Edinburgh. One, James A., practices in England; the other, Colin C., at Quebec. He was a cousin of the late Dr. Stephen C. Sewell, Professor of Materia Medica in McGill College, and of Dr. E. C. Sewell.

Dr. Sewell will be greatly mourned and missed in Quebec, where his kindly disposition and professional skill endeared him to people of all ranks.

Personal.

Drs. Wadsworth and Edes, of Harvard, were in town last month.

Dr. Merrill has been appointed one of the physicians to the Hôtel Dieu.

J. H. Harrisson, M.D. (McGill, '83), has begun practice in Cornwall, Ont.

N. E. Chevalier, M.D. (McGill, '73), of Lewiston, Me., has moved to Iberville, Q.

Archibald McLeod, B.A., M.D. (McGill, '83), has settled in New Westminster, B.C.

The Gilchrist Scholarship of the year has been taken by H. G. Creelman, a graduate of Halifax.

B. E. W. Hurdman, M.D. (McGill, '82), of Aylmer, Q., has passed for the double qualification at Edinboro'.

Hastwell W. Thornton, B.A., M.D. (McGill), has returned from London, and will settle on his estate at New Richmond, P. Q.

We regret to hear of the death of Mr. John Menzies of Pembroke, a third year student in the Medical Faculty, McGill College.

Many members of the profession had the pleasure of meeting Drs. Delmege and Gipps, of H.M.S. "Canada," during her stay in the city.

We regret to see that Dr. John B. Campbell, of Westfield, Cha. Co., N.Y., a graduate of Victoria College, Cobourg, died of an overdose of chloral.

Sir Wm. MacCormac, of St. Thomas's Hospital, spent a day in Montreal, and Drs. Howard and Hingston had the pleasure of entertaining him.

Thomas Gray, M.D. (McGill, '79), late of Brigus, Nfld., has returned from Europe. He intends settling in his native province, Ontario.

William Stephen of Montreal and J. W. Ross of Cohoes, N.Y., and W. A. Shufelt of Knowlton, P.Q. (McGill, '81), have gone to England to pursue their studies.

We are rejoiced to hear that the scandalous statements in the daily papers concerning Dr. Joseph Williams, of Boston, are without reasonable foundation.

Prof. Galbraith of Dublin, of "Galbraith & Houghton's Manuals" fame, is in the country. He attended the opening lecture of McGill Medical Faculty.

R. J. B. Howard, B.A., M.D. (McGill, '82), has returned from London for the winter, to enter upon his duties as one of the assistant demonstrators of Anatomy, McGill College.

Dr. Picault, of Notre Dame Street, was tendered a complimentary dinner on the 20th ult. by the French Societies of the city, on the occasion of the 50th anniversary of his arrival in Canada.

W. S. Oliver, M.D. (St. And.), Brigade Surgeon, has returned, and commenced practice in Toronto. Dr. Oliver was the first to demonstrate experimentally the connection between measley beef and tapeworm. He is also well known as the inventor of improved methods of arranging and supporting the soldier's kit.

Last month we visited our friend and *quandam* city *confrere*, Dr. O. C. Edwards, who is now settled in the new Province of Assiniboia. His home is on the well-known Bell Farm, in the centre of the Qu'Appelle Valley District. We were pleased to observe the success which the doctor has met with in this rapidly-settling locality, his known ability and genial character having rendered him deservedly popular with all.

Medical Items.

—Louise Lateau, the celebrated Belgian bleeding girl, is dead.

—Professor Penhallow, for some years Professor at Tokio, Japan, and lately experimental botanist at the Houghton Experimental Farm, has entered upon his duties as Lecturer on Botany, at McGill College, during Dr. Dawson's absence.

—The New York *Medical Journal* has published an excellent student's number, giving full details of most of the Canadian and all of the American schools. It will be of great service to students and useful for reference to practitioners.

—The Dentists of the Province held a meeting in Montreal on the 10th of September. They repudiated the amendment to their Act passed (unknown to them) last session, which allows

a dentist of ten years' standing to enter upon the study Medicine without passing the Matriculation.

—The Cincinnati *Lancet and Clinic* is responsible for the statement that there lives in Porkopolis a physician who when called to see a case which he does not understand, is habitually seized with a sudden call of nature, and while in the seclusion granted by the haunts devoted to evacuant purposes, he gets out his "ltttle giant crammer" and posts up.

—We had thought that a split fowl to the head (warm) for apoplexy, a hair of the dog that bit you to cure the hydrophobia, &c., were things of the past; but to prove the contrary, it is only necessary to turn to the Patent Office Record of this Dominion for the month of June, 1883. No. 16,845 is entitled a a patent for "Improvements in Ointments," and it informs us that the Department has been graciously pleased to grant a monopoly of the following valuable prescription for a term of five years:—

CLAIM.—A compound composed of the following ingredients: Fresh unsalted butter, two pounds; *black wool cut from the sheep's breast at the full of the moon*, one ounce; three fresh eggs, and flour of sulphur, two tablespoonfuls.

The patentee is one Francis McKay, of Lobo, Ont. Perhaps some of our readers would like to be supplied with this preparation, or to arrange with the fortunate possessor of it to pay a royalty and be permitted to manufacture it for themselves.

THE MEDICAL VOYAGE OF LIFE.—The following clever chronological classification of the ills to which human flesh is heir, may give a faint conception of the gauntlet which we poor mortals have to run: First year: icterus neonatorum, hyperkinesis intestinalis and vaccination. Second year; dentition, croup, cholera infantum and fits. Third year: diphtheria, whooping cough and bronchitis. Fourth year: scarlatina, worms and meningitis. Fifth year: measles. Now half the children are dead. Seventh year: mumps. Tenth year: chorea and typhoid fever. Fifteenth year: hyperæsthesia sexualis. Sixteenth year: spermatorrhœa, chlorosis, and spinal irritation. Eighteenth year: blenorrhœa urethralis. Twentieth year: bubo, alcoholic

cephalalgia, vertigo. Twenty-fifth year: matrimony. Twenty-sixth year: insomnia de infanto. Thirtieth year: dyspepsia, nervous asthenia. Thirty-fifth year: pneumonia. Forty-fifth year: lumbago, presbyopia. Fifty-fifth year: rheumatism, alopecia. Sixtieth year: amnesia, deciduousness of teeth, bony arteries. Sixty fifth year: apoplexy. Seventieth year: amblyopia, deafness, anosmia, general dyskinesis, atonic digestive tract, rheumatismus deformans. Seventy-fifth year: finis.

MEDICAL BARONETCIES.—So far as we can learn, twenty-six baronetcies have been confered on members of the medical profession during the last one hundred years. George III bestowed baronetcies on Sir Walter Farquhar, 1796; Sir Richard Jebb, Sir Everard Home, and Sir Henry Halford, 1809. The baronetcies of Jebb and Home are now extinct. George IV gave baronetcies to Sir M. Tierney and Sir Astley Cooper, 1821. The baronetcy of Tierney is now extinct. William IV conferred baronetcies on Sir Charles Mansfield Clarke, 1831, and Sir Benjamin Brodie, 1834. We believe the following is a complete list of the baronetcies bestowed on members of our profession by Her Majesty: Sir James Clark, 1837; Sir Henry Marsh and Sir Philip Crampton, 1839; Sir Henry Holland, 1853; Sir Charles Locock, 1857; Sir William Fergusson, 1866; Sir James Simpson, 1866; Sir Dominic Corrigan, 1866; Sir Thomas Watson, 1866; Sir William Lawrence, 1867; Sir William Jenner, 1868; Sir James Paget, 1871; Sir Robert Christison, 1871; Sir William Gull, 1872; Sir George Burrows, 1874; Sir Spencer Wells, 1883; Sir Andrew Clark, 1883; Sir Prescott Hewett, 1883. Of the baronetcies conferred by the Queen, one, that of Marsh, is extinct. Of the eighteen medical baronets created during the present reign, eight survive. Of the eighteen Victoria baronetcies, eleven have been given to physicians, five to surgeons, and two to obstetric physicians. All the eight medical baronets now living practise in London.

Married.

GROVES—MONK.—On Wednesday, September 12th, at St. John's Church, South March, Ont., Geo. H. Groves, M.D., Carp, Ont., to Fanny, eldest daughter of G. W. Monk, Esq., M.P.P.

CANADA

MEDICAL & SURGICAL JOURNAL

NOVEMBER, 1883.

Original Communications.

PIGMENTARY DEGENERATION OF THE RETINA IN DEAF MUTES.

(Illustrated by Cases.)

By W. TOBIN, F.R.C.S., Halifax, N.S.

(Read before the Canada Medical Association, at Kingston, September, 1883.)

The subject I have chosen for my paper is one possessing interest not only for the profession, but for the general public, illustrating as it does the sad results which follow a violation of the laws of nature by the intermarriage of near blood relations.

That such marriages have been punished in the offspring by idiocy, malformations and deafmutism you are all aware. That a form of blindness, due to retinal degeneration, complicates, at times, this last affliction, will be shown by the cases I bring before you.

Some months ago, a pupil from the Deaf and Dumb Asylum, in Halifax, was brought to me by one of the teachers, who stated that he had been trying to have him fitted with glasses as his sight had been becoming very defective. The optician had not been able to improve him.

He was a bright, healthy looking young man of 25 years. Externally, the eyes showed no trace of disease whatever, but, on testing him with de Wecker's types, at distance, I found vision reduced to an eighth. He could read Jaeger 14 at 10 inches. There was little accommodation. The pupil was slightly dilated and responded fully to light. With the ophthalmoscope I found the lens and vitreous transparent, but was struck by the

pale, patchy appearance of the fundus, which exhibited here and there solitary dots of pigment. I opened the pupil with atropine, and, on following the vessels, which were much diminished in size, towards the periphery, lost them in masses of black pigment, which formed a complete circle round the retina. This pigment was arranged in a lace like pattern. The whitish patches corresponded to denuded portions of the choroid, where the vessels were laid bare and seemed altered in structure. I had seen some similar cases at the clinique of my friend and teacher de Wecker in Paris, and recognized it as one of Pigmentary degeneration.

On inquiring into the history of the lad, I learned that his sight had been gradually failing for some time, that he could not read except in bright light, nor guide himself about with safety in the dusk of the evening. He was one of four deaf-mutes in a family of twelve children. They were all four losing their sight, and the eldest, a woman of 42, had already become blind. The other children were healthy. On expressing a wish to see more of the family, two others of the deaf-mutes came to see me. One was an intelligent young woman of 32, the other a fine lad of about 22 years. Both had been born deaf and dumb. I found them to be affected in the same way as the brother, but the disease was more advanced with them ; and the girl had, in addition, in the other eye a post polar cataract. She had been a great reader. I did what I could for them—which unfortunately was not much—and saw no more of them till quite lately, when, in order to investigate their cases more fully, I followed them to their home in the country.

There I found the father still alive, an active and energetic old man of 75, who freely volunteered all the information required.

His parents, he stated, had lived to a great age, and had both been well formed and healthy. They had only taken to glasses late in life. They had had eleven children, all sound in mind and in body. Neither did their children's children (bar his own) suffer from nervous affections, deaf-mutism, or deformity —nor did he know of any such defect, in distant branches of

the family. His own sight had been bad from childhood, and he suffered much at school in consequence. At 20, the fault (a strong hypermetropia) was discovered and corrected with glasses. He had constantly worn them since then, but found of late years that he required them weaker than formerly. His eyes were very small (microphthalmos). His general health, he said, had always been good. He was well formed. His wife, the mother of the deaf-mutes and the eight other living children, had been a healthy woman herself, and came of healthy parents. She had died of heart disease at 50. She and her husband were near blood relations.

Of their twelve (12) children, five were girls, seven boys. The eldest, now a man of 47, was healthy. The second (Nancy), a woman of 42 years, was born deaf and dumb and was now blind into the bargain. The third, fourth and fifth (the two last twins) were healthy, though the twins required glasses. The sixth and seventh children were girls—one has imperfect sight, the other is asthmatic. The eighth (Jane), aged 32, was the one who had been to see me in Halifax. The ninth and tenth (boys) are healthy. The two last (Cotis and George) are the other deaf-mutes of the family. All the boys but the two last are earning a living in the States. Two of the girls are married and have raised healthy families. One other girl (unmarried) remains at home to look after the four unfortunates who require constant attention. I examined her eyes and found her slightly astigmatic. A. H.+2 D. Corrected by C.+2 D at 120. Otherwise her health is perfect.

I subjoin the cases of the four deaf-mutes more in detail.

Nancy, aged 42, of dark complexion, born deaf and dumb, and with bad sight. Had to use magnifying glasses at school, which the state of her eyes obliged her to leave at 22. Has not been able to read for the last ten (10) years, with any glasses. Cannot now follow the finger alphabet. Suffered from same symptoms in the other. Not examined further.

Jane, aged 32, dark complexion, dark hair, brown irides. Nervous temperament, very intelligent. Was born deaf and dumb. Passed six years in the Halifax Asylum. Sight failed

while there. Began with night blindness. Latterly vision has become very defective. Requires a strong magnifying glass to read (+14 to+16 D.) Cannot find her way about, out of doors, in the evening. When the snow is on the ground is apt to lose the path. Employs herself in the house in spinning. No external eye disease visible. Pupils large, not very sensitive to light. Vision for distance with de Wecker's type. Right and left eye 1-12th. Not improvable with glasses. Reads Jaeger 10 at 7 inches. Accommodation feeble.

Visual field, as tested by Landolt's perimeter, is reduced to a circle of ten degrees, round the fixation spot, for white, with smaller circle for red and green colours. Blue could not be distinguished.

Ophthalmoscopic appearances: The lens shows a stellate, post polar cataract, best seen by oblique light. The vitreous is free from opacities. The retina in the neighbourhood of the disk contains scattered masses of pigment, which abounds at the periphery. The retinal vessels are reduced in size. Their walls are thickened. There is no atrophy of the disk. I examined the throat and the ears, but except that the tympanic membrane was opaque found nothing unusual.

George P., the last brother similarly afflicted, is aged 22. He presents the same healthy appearance as the others. Has never suffered from any particular ailment. Was born deaf and dumb. Sight began to fail in childhood. Complained first of night blindness. He was, however, taught to read and write at the Asylum. Now can scarcely do either, even with glasses. Staggers a good deal in his gait and knocks against objects in the room, when moving about. Works on the farm and does well enough in the daytime, but has to leave off before evening. As he cannot hear, and his visual field is much diminished, one has to be careful about going near him when chopping wood, thrashing, &c. Vision for distance in either eye equals 1-8th slightly improved by a + 2 D glass. Reads Jaeger 14 at 6 inches with difficulty. Takes a + 6 D for reading and requires a bright light and his back to it. Little accommodation. Pupil dilated and inactive. No external signs of disease. Media

transparent. The retina presents same appearances as in sister's and brothers' cases. Pigment more abundant. No atrophy of disk, vessels reduced to threads and showing signs of sclerosis, membrana tympani indrawn and opaque. Throat slightly granular, has been suffering from catarrh.

His visual field is reduced to 15 degrees above, 15 to the nasal side; 10 degrees below and same to the temporal side. There is a slight difference between the field in either eye. He has no loss of colour, having a field of 10 degrees for light green (about same as white), 8 degrees for red, and 5 for blue. The last colour he found it hard to distinguish.

The other brother's case has been already gone into. I found his visual field also much contracted. His color sense was unaffected. The were no signs of disease in ears or throat.

In all those cases, torpidity of the retina, which requires the brightest light to stimulate it, and a form of night blindness, which makes it impossible for the patient to read or work or get about in the evening, are the first symptoms, and may be the only ones for years.

A gradual contraction of the visual field follows, limiting the patient's vision to one object at a time, central vision remaining unaffected, till the disease, in a gradually contracting circle, reaches the macula, when sight is abolished for ever. The patient may be able to read the finest print up to the last. This was not so, however, in my cases.

Pigmentary deposits in the retina were first described by Langenbeck in 1836. Ammon followed in '38 with two cases. Donders and Von Grafe gave us the characteristic ophthalmoscopic appearances, and traced the connection of the disease with deaf-mutism and consanguine marriages. Donders in 1857 published an anatomical study of the disease to which he prefixed its present name—Pigmentary retinitis. To Leber, Broussais and Pope, so late as 1868, we owe more of our knowledge of the subject.

Pigmentary retinitis is described as a very slowly progressive, symmetrical disease, leading to atrophy of the retina, with great

contraction of its vessels and accompanied by the collection of black pigment in its layers and around the blood vessels (Nettleship). It generally begins in childhood—sometimes it has gone through all its phases in utero and the child is born blind—rarely it appears in advanced life—when its progress is more rapid (de Wecker). The disease is strongly hereditary (Von Grafe), affects the boys of a family more than the girls —not so in the present instance—coincides sometimes with deaf-mutism or idiocy (Jaeger) and appears generally in children who are the issue of consanguine marriages (in 40 to 50 per cent according to Zubrich, in 25 per cent only according to de Wecker) and appears in others who are affected by congenital syphilis (Galezowski). Some of its subjects are healthy both mentally and physically (as in my cases); others are ill-formed and intellectually defective. Errors of refraction may complicate the disease, usually Hypermetropia. It is always binocular and symmetrical in progress. "The typical cases are congenital, but this variety, which follows a slow course, ending about 40 in complete blindness, is not accompanied by arrest of development, by deformities, or defective intelligence" (de Wecker.)

The fundamental characteristic of the disease consists, according to Jaeger and de Wecker, in a slow and progressive proliferation of the cellular element of the external retinal layers and their transformation into a dense tissue, accompanied by a hypergenesis of the cells of the epithelial layer, which penetrate the degenerated retina. The three changes which that membrane undergoes are :—1st, a softening of the external layer, accompanied by proliferation of the epithelial cells ; 2nd, a hyperplasia of the cellular tissue contained in the external granular layer, involving the destruction of the rods and cones ; 3rd, a sclerosis of the retinal vessels, leading to a thickening of their walls, with a decrease in the column of blood. This want of blood, added to the destruction of the rod and cone layer, explains the torpidity of the retina, which precedes the pigmentation. The vitreous and choroid may be unaffected, though the stroma of the latter is laid bare and its vessels may undergo sclerosis.

"We remark, then, in this affection, a progressive atrophy of the retina, which advances from periphery to centre, attacking first the sensorial layers and ending by destroying the conductory elements of the optic nerve itself" (de Wecker, Therapeutique oculaire.)

The characteristic ophthalmoscopic image may not be present in the beginning. The primary lesion is the sclerosing degeneration, which precedes in the retina the migration of pigment and which appears first where the nervous tissue is least abundant, namely, at the periphery. "The quantity of pigment varies with the date of the affection, and, in the beginning, in young subjects, when the cellular tissue which takes the place of the nervous elements has not yet undergone a sufficiently defined retraction, we may find no pigment whatever.

"The pigmentary degeneration begins by the apparition in the most peripheric portion of the retina of small clots of pigment, presenting a star like pattern, which has led them to be compared to the lacunæ in bone, several of these coalesce, throwing out branches to similar spots in their neighborhood. The walls of the vessels form an attraction for the pigment which accompanies their course in places, in others completely obscures them. It is found most plentifully between the forks of their branches. As the disease progresses, the pigment spreads over the whole fundus, like the links of a coat of mail, from circumference to centre, till the macula is finally invaded. In the later stages a yellowish-white atrophy of the disk may be noted. The vessels are diminished to threads or disappear altogether at a distance from their origin. The tenuity of the vessels is due to the sclerosis which has attacked their walls. A double white line enclosing a thin column of blood is all we can see of the arteries. The vessels of the choroid are laid bare by the peeling of the epithelial layer. They may also suffer from sclerosis. Post polar cataract may be present, but remains stationary for years and is confined to the cortical substance. Vitreous opacities are uncommon."

Such, gentlemen, are the ophthalmoscopic appearances of this disease, as described by de Wecker, in his "ophthalmoscopic

clinique," a description which tallies perfectly with that presented by the case I have brought before you.

Since writing the above I have come across another instance of this affection, in a woman from the Poor House, Catherine B., aged 50, who came to me complaining of gradual loss of vision. She was born in Ireland, of healthy parents. Her brothers and sisters (5) were also healthy. She had never suffered from any particular ailment herself till sight began to fail which is nine years ago. She was neither deaf nor dumb. Her parents were in no way related. Eight years ago she first found trouble in reading. Then flashes of light and flying plays of colour would appear before her eyes. Next she could not work in the evening: within the past four years she has not been able to mount the Poor House stairs after night fall. Sight has gone more quickly since she got a fright at the great fire there last November.

V. R.=1-20. Cannot read largest type. Counts fingers.

V. L.=1-12. Reads de Wecker 8 at 10 inches. In the right eye, visual field is reduced to a circle of 5 degrees and she cannot distinguish colors. In the left eye the field is somewhat larger but she takes blue for red and green for white. With the ophthalmoscope, the disk in both eyes looks indistinct and hazy. There is an abundance of pigment, scattered in large patches all over the fundus; in the right eye the disease has encroached on the macula region. Large patches of choroidal atrophy in both eyes. Choroidal vessels visible as white ribbons containing no blood. Retinal vessels very small. The walls hyaline, thickened, containing a thin stream of blood. The disk in the right eye very pale. Hearing and speech perfect.

This case is interesting as showing that the disease may exist without any consanguinity between the parents. I have seen it in a child of ten years under similar circumstances (not a deaf-mute either). In the next case it appeared late in life, and in a woman. De Wecker states he has rarely seen the disease in a female. Again there is a want of symmetry between the two eyes, vision is much more defective in one than in the other. There was no change in the lens in either eye, though the last stage almost had been reached by the right one.

Treatment in all these cases is hopeless. Generous diet, attention to general health, and the use of occasional hypodermic injections of strychnine, is all that can be recommended. Any error of refraction should be corrected with suitable glasses and if there should be (as there rarely is) an over-sensitiveness of the retina, colored glasses or a shade may be ordered.

Unfortunately these cases, in spite of all treatment, tend slowly towards hopeless blindness.

SUCCESSIVE DROPSIES OF THE AMNION ALWAYS SPECIFIC.

By JAMES DORLAND, M.D., Milwaukee, Wis.

(*Read before the Canada Medical Association, at Kingston, September,* 1883.)

Case I.—Mrs. D., aged 30, full habit of body, and apparently healthy. Was called to attend her for the first time, in her fifth confinement, July 16th, 1880. Found the os fully dilated and membranes very tense and bulging with fluid. Externally, found the abdomen high up, interfering somewhat with respiration, the skin very tight, and palpation giving evidence of a large amount of fluid. Ruptured the membranes, and it was followed by a great gush of water, then the child, and another large quantity of fluid. The amount was between eight and ten quarts, but certainly not less than the former. The fœtus proved to be about seven months old, and had been dead about 24 hours. She said it was not an unusual amount of water, as in all her previous confinements she had about the same quantity. Had been married to a sailor eight years. Could give no reason why so much water would form. The other four children were still-born at four, six and seven months. Had been treated for it at various lake ports, but derived no benefit. Knowing the habits of sailors, I began to look about for a cause, but both of them denied ever having any specific disease. I was not fully convinced, and determined, when she again became pregnant, to put her on specific treatment.

About the 1st of January, 1881, finding her in that condition, I began treatment, and continued it thoroughly until she had passed the seventh month and was well on towards the eighth.

July 16*th*, 1882.—Was called; found the membranes ruptured and about half the liquor amnii in a pail. It measured six quarts. When the water flowed freely, she would get up and go to the pail, and wait until the pain was over. I do not think it any exaggeration to state that as much was lost on the bed-clothes and floor. When the child was born, about another quart came away, making 12 or 13 quarts altogether. Contrary to my expectations, the child was alive and lived two weeks before death, presenting the characteristic old man appearance of syphilis.

When she again became pregnant, consented to take medicine, and it was pushed thoroughly. About ten days before labor she began to enlarge quite fast, and upon examination, found more fluid than normal. Had stopped all treatment for about three weeks previous; now, however, I again began giving Potassium Iodide ℈i per day, which acted on the bowels quite freely. I continued it until the birth of the child. About the fifth day after taking the Pot. Iod. the movements of the child became stronger, and the tenseness gave way.

July 6*th*, 1883.—I delivered her of a 10 lb. boy, with only slight traces of syphilis, and no undue amount of fluid.

Case V.—Mrs. S., aged 41, short and robust, the mother of nine children. The first was born in Scotland, the second in England, five in Greece, the eighth in England, and the ninth in the United States. Generally noticed that she began to enlarge quite rapidly a fortnight or six weeks before the birth of her children. First child still-born, with an immense quantity of fluid; fifth, a large amount, but the child was alive, and died two weeks after; eighth child only lived 20 minutes, and she thought the death was due to too much fluid. I was called to attend her with the ninth; found the os fully dilated. I ruptured the membranes and collected six quarts of water; not more than a pint escaped. The child, a male, weighed 13 lbs., and died 15 minutes after birth. The cord was 12 inches long and fully an inch in diameter. She was confined March 23rd, 1883, Could get no specific history from either parent.

CASE VI.—Mrs. W., aged 38, spare habit of body, the mother of five healthy children by her first husband. Her second one had three by his first wife, all healthy. He contracted syphilis and gave it to this one. They paid very little attention to medicines prescribed; only when some external manifestations were present, and painful, they would use some local application until relieved. During this time, which was in 1881, she became pregnant, and, contrary to advice, stopped treatment. At the eighth month she had some severe pains, and sent for me. Upon examination, found the os dilated so as to admit the tip of the finger. The membranes were as tense as they should be during a severe pain. A great change had taken place in her abdomen, it being enormously distended. It was symmetrical, and pushed up the diaphragm so that respiration was very much interfered with. Expression anxious. Said the skin felt as though it would burst. Gave her an anodyne. The following day she had a chill, and four days after, labor came on. I arrived a few minutes after the membranes had ruptured, and found the bedding and carpet saturated with water. The patient was in an anxious frame of mind; felt sure death was approaching, as, to use her own words, she had collapsed. Said she had passed fully 24 quarts of water, a great gush following and during a second pain. I soon delivered her of a still-born child. At the lowest calculation, there could not have been less than 20 quarts, and I firmly believe, could it have been collected, it would have reached 30, for I have never seen such a flood in a parturient chamber.

Remarks.

CASE I.—This patient, after having five still-births, all with dropsy, was able to have, after one thorough course, three children in succession, all born alive—the two first without dropsy, and without any sign of syphilis; the last with dropsy and a showing of syphilis, but still alive, and with fair prospects of living. But the last case also shows that some of the effect produced by specific treatment is beginning to wear off. After this last one, I received my first intimation from her that she had ever been diseased, but I had long since found out I was right from a sister

of hers who came to the city later and entered a house of prostitution.

CASE II.—This is also a very valuable one, for here we have six cases of dropsy following in succession, the seventh, under specific treatment, being born without, and perfect in every respect, and free so far from any sign of syphilis. The next, or eighth child, with no treatment whatever, again born with dropsy, and dead. The ninth, after quite a thorough course, was also born alive, and without dropsy or any signs of syphilis. The husband proved to be the guilty party in this case, and probably that was the reason the first thorough treatment was not sufficient to tide the next one over till full time.

CASE III.—Although I did not see the two children that were born with dropsy of the amnion, the report is perfectly reliable, and I think to the specific course of treatment can be attributed the next two natural births. The father had also, after the birth of the second child, taken further treatment.

CASE IV.—Here we had two cases of dropsy, the husband known to be syphilitic; the third, after the mother had been treated, born alive and with no dropsy, but still with slight traces of syphilis on the palms of the hands and soles of the feet. The father in this case had a very severe attack, and took but little medicine, so that his blood is in a much worse state than any of the others. It is to that I assign the reason of the thorough treatment of the mother not removing every trace of syphilis from the child.

CASE V.—Although not mentioned in my report, all the nine children that were born had dropsy of the amnion, the ones I specified being the most excessive. Although no history from father or mother that would point to syphilis, the condition of the living children, their stunted growth, saw-edged teeth, general appearance, and the illness of one of them, for which no cause was apparent, and which had not yielded to other forms of treatment, and which potassium iodide readily cured, leave scarcely a doubt in my mind but that the father or mother has had syphilis, or is the victim of an inherited taint.

CASE VI.—Although no direct bearing on successive cases, the fact that there could be no doubt as to the cause of the dropsy and the excessive amount of fluid led me to report the case.

These are the facts I have to lay before you in support of my theory that successive dropsies of the amnion are always specific; facts that cannot be obtained from our lying-in hospitals, but from private practice, where attendance on a family has extended over a number of years, and where you have the time and patience to ferret out the cause of diseases from many who do not care to have you know their previous misfortunes, or do not inform you for fear of further complications. In hospitals we seldom see the same patient twice, hence the conclusions arrived at there would be of no use either for or against this theory. That syphilis has caused it, has more than once been advanced, but generally denied, and I think the Germans are the only ones who put much faith in it. That syphilitic children are born without dropsy often happens, for no doubt most of you have seen such cases. These cases of dropsy could not have arisen from any other cause, for there is no history in any of the cases of any inflammation of the amnion, for not one of them suffered from the least bit of pain, but only discomfort, after the fluid had accumulated. Very few of them ever had a chill, and in those the dropsy was present before that time, and the chill only seemed to mark the death of the infant, and not always that. None of them ever had any general anasarca during gestation, and their kidneys always seemed to be fairly active. It could not have been disease of the heart and kidneys of the infant, because some of them were born at such an age, as the one at four months, with about four quarts of fluid, that it would be an utter impossibility; besides, many of them were born alive, and are still alive, and, in most of the cases, even at full term, the dropsy came up in such a short time that the kidneys of no infant could have secreted the amount. I was sorry that I could obtain no post-mortems of the cases I attended, but even had I found hypertrophy of the heart or kidneys, I should have placed no stress upon it, for I do not believe it could cause it, nor that

we have any facts that point in that direction. The death of the fœtus and osmosis could not have produced it, for the same reason stated above, that many of them were alive, and lived some time after birth. It has seemed to me that it would be impossible to have a dropsy except from systemic infection producing changes in the amnion, or following a debilitating disease, like latent pleurisy often does; but that all these cases were in good health shows that it was not due to the latter, but to a poison which can lurk for years in the system, and, as far as outward signs go, give no evidence of its presence. Such a poison is syphilis, and I believe that if not the only cause, it is the one *par excellence*, and the only cause of successive cases.

Cases 1 and 2 would, I think, have been sufficient for my purpose, but the others were added because in unity there is strength. These cases all happened in mothers who spent many hours in grief because of the loss of their children and their inability to have them born alive; and if to any such among your patients relief is brought, I shall feel amply repaid.

OUR LONDON LETTER.

(From our Special Correspondent.)

OPENING OF THE SCHOOLS—LISTERISM IN LONDON—GASTROSTOMY.

Although barely a fortnight has passed since the several London Medical Schools were opened for the session of 1883-4, everything seems already to be running at full speed. There is such an amount of rivalry existing between the large schools and such a scramble for existence in the case of the smaller ones, that the work of teaching is kept up to high pressure mark for at least nine months in the year. There are now so many schools having men attached to them equal in ability and reputation, that students and their friends often find it no easy matter to make a choice. The tendency is to crowd to the schools attached to the larger hospitals, the general impression being, of course, that the more patients the student sees the more he is learning. I think it will be found, however, that in the smaller hospitals, such as King's College, University College, and St.

Mary's, for instance, where no surgeon or physician has more than thirty beds, the material is much better worked up, and the student really benefits more.

Many of the schools opened with the old fashioned "introductory," while others began work quietly on the first of October. The Guy's men held a conversazione on that day, while the St. Mary's men had their annual dinner of "students past and present." This latter proved to be a very pleasant gathering. Some two hundred sat down, the present students being represented almost entirely by those of the final year. Men came from all parts of Great Britain and two or three from France in order to meet old mates and compare notes. By the way, St. Mary's is rapidly coming to the front as a school of medicine. The Faculty have just opened a new building immediately in rear of the hospital, their old quarters having become too small to accommodate the increased number of students. Mr. Fields, lecturer on aural surgery, is their newly elected Dean. He has always evinced a deep interest in the welfare of the school, and altogether the appointment is considered an admirable one. He is what one of the speakers at the dinner called "an honest specialist."

The London Hospital Medical School was opened with an address by Professsor Huxley, who also distributed the prizes to the successful students and nurses of the past session. The learned professor chose for his subject the "intervention of the State in the affairs of the medical profession." The address was evidently well thought out, although disappointing in some regards. He is apparently a great conservative in the matter of medical legislation, and believes that the Act, which came into operation in this country nearly thirty years ago, should, with very slight modifications, still be made to meet all the requirements of the present day. He contended further that the State should take no part in protecting the general public against incompetent persons, but that "every one should choose his own way to be killed." Fortunately he modified this extraordinary statement later on by suggesting, that in the event of death, none but medical experts should be allowed to give evidence.

In another part of his address the professor made certain suggestions regarding the course of medical study, and he was listened to with marked attention. For instance, he advocated the foundation of two or three central institutions for the teaching of anatomy, physiology, and chemistry only, the teachers to be specialists in these subjects. From these "institutes of medicine," after a year or two, the students would go to the various hospitals to get a practical acquaintance with the phenomena of disease. While much may be said in favor of such a scheme, the question arises, is it wise to place medical students, for so long a time, under the guidance of specialized physiologists and chemists? The latter are not likely to know the real wants of the medical student, but would be apt to spend much valuable time on the study of subjects having little, if any, direct bearing on practical medicine.

It is very noticeable that many of the older men, whose names with us are veritable household words, are, from various causes, rapidly withdrawing from the teaching arena of London. Some have the good excuse of advanced years; others are too much absorbed making hay now that their sun (obscured, perhaps, for many long years) has at last shone out; whilst a third class have been obliged to retire in order to conform with an absurd rule which shelves a man after twenty years' service. One of the victims of the heinous law just referred to is no other than that able surgeon and pathologist—that great all-round man, as his friends like to call him—Mr. Jonathan Hutchinson. I am wrong in calling him a victim, because he has well earned the rest thus given him, and will doubtless profit by it as far as health is concerned. But it is the London Hospital itself and its school which will suffer, because his place cannot be filled for years, if indeed they ever raise a man with such professional instinct and remarkable teaching qualities as Mr. Hutchinson possesses. In order that his name may still be retained among the list of teachers, the Faculty have made him Emeritus Lecturer on Surgery, and he has consented to deliver one lecture a month during this session. As a consequence of all this, the younger men attached to the various hos-

pitals, chiefly of the rank of assistant-surgeon, do the great bulk of the teaching. This is right and proper, and for didactic teaching nothing could be more suitable, but one would like to see opened more frequently those great store-houses of clinical knowledge which must and do exist in this city. I have been disappointed already a score of times in going round hospital wards with some of the ablest men here, to find how little they utilized, for teaching purposes, the vast amount of material at their disposal. Fortunately there are two or three marked exceptions to this rule, but often these are not appreciated to the extent one would like to see, at least judging from the number of students attending their respective classes. One of these exceptions, I cannot refrain from mentioning, is Mr. Lister, who is acknowledged on all sides to be a most painstaking clinical teacher.

Speaking of Mr. Lister, there are many who think that he made a great mistake in coming to London; not on his own account of course, because he has as large a *clientele* here as he ever had in Edinburgh; and besides he is quite independent of practice. I refer to his position as a teacher and hospital surgeon. In Edinburgh he yearly infused into the minds of at least three hundred medical students those great surgical principles of which he is master, and sent scores away every year to all parts of the earth to preach the gospel of Listerism; now he influences a mere corporal's guard. I have been agreeably surprised, however, to find that the majority of London surgeons have adopted Lister's method. In the London Hospital Mr. Cooper is a great enthusiast in that direction, and has succeeded in converting nearly all his colleagues to his belief. In St. Mary's Hospital, all the surgeons but one operate under the spray and use the gauze dressings. In St. Thomas', Mr. Croft and Mr. Sydney Jones—the only men there whose operations I have yet witnessed—carry out Mr. Lister's directions almost to the letter. In fact in no hospital in London, have I failed to find some evidence of Lister's teaching, so that while his plan may not be carried out in all its details, the main principles are there, and require time and experience only for their complete development.

THE SONIER FAMILY.

First Generation.		*Second Generation.*		
Joseph Sonier came to Tracadie from Cumberland or Westmoreland in 1790.	Peter Sonier. Alexis Sonier. Mrs. Finn. Ann Sonier. Mrs. Savoy. Rosalie Sonier. Mrs. John B. Arsenau. Isabel Sonier. Bridget Sonier. Mrs. Mary Gould. Nasturia Sonier. Florazine Sonier. Mrs. Capt. Gould. Moses Nowlan.	No leprosy in this family.	Peter Sonier, married Perpetue Savoy.	Joseph Sonier. Francois Sonier, contracted leprosy by carrying Ursule Landry's coffin. John B. Sonier, married a Robicheau, who has had leprosy 40 years; now in lazaretto. Arthur Sonier, died of leprosy; married a Brideau, who was washerwoman in lazaretto, and escaped. Ursule Sonier (Mrs. Holmes)—child died of leprosy. Ide Sonier, first wife of Frank Robicheau, who had 3 wives, died of leprosy; he himself escaped. Marie Sonier, married Fournier. Isabel Sonier, married Comeau.
			Alexis Sonier, married Charlotte Comeau, who died of leprosy.	Charles Sonier. Dominick Sonier. Frank Sonier. Olivier Sonier.
				None of this family, but some of their children, died of leprosy.

A number of Soniers still live in Westmoreland, none of whom ever had leprosy.

The Brideau Family.

Three brothers, Brideaus, came from Paspebiac, in the Province of Quebec about 1790-95.

- Leon Brideau, married a Comeau, — None of this family died of leprosy.
- Louison Brideau —
  - Marie Brideau, married J. B. Arsenau. None of the children, but some of the grandchildren, died of leprosy.
  - Frank Brideau, married McLoughlin; Louis " " "; Prosper " " Robicheau of Pokemouche. Children died of leprosy.
  - Fidele Brideau, married Brean. Fidele died of leprosy.
  - Genevieve Brideau, married a Vineau. No leprosy.
  - Lawrence " " Robicheau. No leprosy.
  - Charles " " Savoy. Children died of leprosy.
  - Matilde Brideau, married Ferguson. One child died of leprosy.
  - John B. Brideau, married Savoy. Died of leprosy.
- Louis Brideau.

The Robicheau Family.

First Generation.

John Robicheau, an early settler.

Esther Robicheau,		
Fairie	"	
Rachel	"	son died of leprosy.
John	"	died of leprosy; the 6th victim.
Frederick	"	
Joseph	"	
Frank	"	died of leprosy.
May	"	

Second Generation.

Jos. Robicheau.

J. E. Robicheau.		
Mary	"	leprosy.
Margaret	"	married a Savoy.
Charlotte	"	
Daniel	"	married a Savoy.
Delahid	"	
Lazille	"	
Balomi	"	leprosy.
Julie	"	married a Thibadeau.

Frank Robicheau died of leprosy.

Frank Robicheau, who had three wives—Ide Sonier, Monica Russel, and Domitia Brideau—all of whom had leprosy, while he escaped the disease.
Margaret Robicheau, leprosy.
John "
Charlotte "
Louis "
Olivier "
Delahid "
Israel "

The Comeau Family.

About 1790, Charles Comeau came to Tracadie. Married Margaret Roy of Bathurst.

Charles Comeau,		leprosy.
Dominick	"	
Joseph	"	
Thomas	"	leprosy.
Alexander	"	leprosy.
Benoni	"	leprosy.
Margaret	"	
Mary	"	
Charlotte	"	

Charles Comeau, died of leprosy. Married a Casey, who also died of leprosy.

None of this family had leprosy.

Abraham, Registe, Remy, Cyprian,	These remained in the parish. Children of at least three had leprosy.
David,	Married and removed away. No children had leprosy.
Vivien,	
Veronique, Tranquille,	Both married and left the country. None of the children had leprosy.

Joseph Comeau, married Thibadeau.	Lawrence Comeau, leprosy. John B. " Mary " Genevieve " Mary " Vivien " Budger "
Antoine Comeau, married a Thibadeau.	Romain Comeau, leprosy. Olivier " Boswell " leprosy. Dorothy " Madeline " May " Mary " Genevieve " married Mrs. Chas. Losier. Mrs. John Losier.
Elvina Comeau, married a Thibeaudeau.	Mary Comeau.
Afterwards married An. Sonier.	Alexe Eugene Margaret
CharlotteComeau married Goutreau.	John B. Goutreau, leprosy. Fabian " Clement " Margaret " Mary " Julian " leprosy. Veronique "

A number of Comeaus have been constantly in hospital, descendants of the families.

Charles, Joseph, Antoine, Elvina and Charlotte Comeau were brothers and sisters, who came to Tracadie in early life and married into the neighboring families. Leprosy did not previously exist in the Comeau family, nor in any with whom they became connected, until it broke out with great virulence in the generation given.

It will be noticed that the disease did not exist in the first generation of the Sonier family. This is accounted for by the fact that they were a much older family than the others, and had either died or reached old age before the outbreak of leprosy in the parish. It might be stated here, however, that old age is no absolute barrier to the spread of the disease, as one undoubted case was admitted into the hospital at the age of eighty.

QUARTERLY RETROSPECT OF OBSTETRICS AND GYNÆCOLOGY.

PREPARED BY WM. GARDNER, M.D.,
Professor of Gynecology, McGill University; Attending Physician to the University Dispensary for Diseases of Women; Physician to the Out-Patient Department, Montreal General Hospital.

The Treatment of Uterine Myoma.—Since my last report a good deal has been written on this subject. The resources of operative gynecology for the treatment of these tumours have been greatly amplified in recent years. Schröder, Martin and Gusserow in Germany, Spencer Wells, Thornton and Lawson Tait in England; and Gaillard Thomas in America, have done the most to bring the surgical treatment of fibroids to its present position. Happily for the sufferers it is only numerically a small proportion of these growths that requires surgical treatment.

Dr. R. Lomer, assistant at the Berlin University Women's Clinic, writes an able paper on the Enucleation of Myoma (*Zeitschr f. Geb. und Gyn.*, Bd. ix., Hft. 2, Sept. 1883).

He begins by a statement which may be taken as the *raison d'être* of his paper. "Since the recent devolopments of laparotomy in the treatment of myoma the question of enucleation by the vagina occupies a new position." He refers principally to the recently published results of myomotomy by his master, Schröder. These results render it necessary to compare the relative advantages of the two operations and to define the limits of applicability of each. In his opinion, in view of the great mortality after the removal through the vagina of intra-uterine fibroids in cases of undilated rigid cervix; cases in which preliminary dilatation so dangerous is absolutely necessary; the operation of removal through the vagina should be restricted to cases:

1st. Of myoma of the cervix and os uteri, and

2nd. Of submucous and intra-parietal myoma which have dilated the cervix and thereby rendered themselves accessible through the vagina.

The author believes further that for all other cases laparotomy must be performed, and the tumour either amputated or enucle-

ated through the abdominal wall. He emphasizes the great importance in all enucleations through the vagina of the subsequent treatment which is to be the same as for septicæmia in the puerperal woman. The value of continuous irrigation of the uterine cavity now so much employed in Germany in such cases is insisted on, and instances cited from the records of the Berlin Woman's Hospital in which it had a marked antipyretic effect. In two cases in which during the past summer I removed sessile submucous fibroids by the vagina, the after treatment consisted in daily irrigation of the uterine cavity and the subsequent introduction of a few grains of iodoform to the uterine cavity by a suitable instrument. Convalescence was not interrupted by a single bad symptom. In this paper Lomer also discusses those formidable cases of labor complicated with myoma of the cervix, cases in which the tumour lying in the pelvis prevents the delivery of the child. In some such, as in cases described by Playfair, Löhlein and others the tumour can be pushed up at the time of labor. During the past summer, in consultation with Dr. D. C. MacCallum of this city, I saw a case in which this was effected without great difficulty, and the living child delivered by version and forceps to the after-coming head. But in many of these cases this is not possible. In these the author advises incision of the capsule and enucleation in preference to the Cæsarean section so often advocated. In support of this practice he adduces several cases recorded in medical literature and a recent one now published for the first time. This case occurred to Prof. Schröder.

At the recent meeting of the British Medical Association this subject was one of those under discussion. Papers were read by Mr. J. Knowsley Thornton, of London, "On the Operative Treatment of Uterine Fibro-myomata"; on "Myomotomy" by Prof. Carl Schröder, of Berlin; "On the differential Diagnosis of the various Forms of Fibroid Tumours of the Uterus," by Dr. Alfred Meadows, London; and "A case of Hysterectomy for Uterine Fibro-myomata," by Dr. Walter, Manchester.

Mr. Thornton gives the result of his experience in the surgical

treatment of these growths. When subperitoneal and pedunculated, and if they give rise to symptoms he removes them, securing the pedicle by silk ligature. He has operated in cases in which the size—the unsightly swelling of the patient was the only consideration rendering it advisable. In the case of sessile subperitoneal tumours he has operated three times with one death. The cut surfaces were dealt with by ligatures and sutures. He has removed five uterine fibrocysts. All recovered. One was treated by Wells ovariotomy clamp, two by enucleation and ligature, one by cautery and ligatures, and one by simple transfixion and ligature.

For intra-mural tumours, by far the most serious and dangerous of the class he has done partial hysterectomy three times. All the patients died. He thinks that when possible the extra-peritoneal method of dealing with the cut surface is much the safer. He has performed complete supravaginal hysterectomy twelve times, on each occasion removing both ovaries. In these also when possible the pedicle was treated externally; unfortunately, as Mr. Thornton believes, it cannot always be thus treated, but must sometimes be disposed of in the abdominal cavity. Seven of the twelve recovered.

The submucous variety, if single, he treats by rapid dilatation of the cervix with Hegar's wooden dilators and immediate enucleation. Before operating he thoroughly cleanses the vagina and if possible the uterine cavity by antiseptic irrigation before commencing dilatation. After the removal of the growth he sponges out the uterine cavity and wound with tincture of iodine. If necessary to arrest hemorrhage he then uses perchloride of iron. Since adopting this rapid method he has not had the slightest anxiety after enucleation. If these latter tumours are multiple as often happens, and in the great majority of intra-mural growths, he advises the removal of the uterine appendages, an operation for which he believes there is a brilliant future. This latter operation he has done fifteen times without a death. He advocates its performance before the tumour grows large, as then the prospects are by no means so good. His experience is opposed to Lawson Tait's idea that the Fallopian tubes

influence menstruation. He believes, however, that to obtain good results not only must the ovaries and tubes be thoroughly removed, but they must be removed in such a way as that the blood supply of the uterus is very materially influenced by their removal. "In other words the ligatures which transfix the broad ligaments must be so applied as not only to enable us to cut the ovaries and tubes away safely, but at the same time to cut off from the tumour the very important blood supply which it obtains from the enlarged ovarian, tubal, and other vessels."

Prof. Schröder said, "The prognosis of the removal of large solid tumours of the uterus by laparotomy depends altogether upon the development of the technical methods of operating. The important points that are requisite are: 1. A method of operating without great loss of blood; 2. A method of forming a good pedicle, safe against hemorrhage." He then stated that he believed he had found such reliable and not too difficult methods as to make it possible to operate on even the most difficult cases. His method in removing subserous myomata with narrow pedicles in no wise differs from that of other operators. In sessile subserous and interstitial tumours he is generally able to extirpate the growth without the uterus or its appendages. A thin solid India-rubber ligature is placed temporarily round the body of the uterus. The tumour is then removed by V-shaped incisions, or its capsule is incised and it is shelled out. Different layers of stitches are now used; those of the first layer unite the deeper parts of the wound. These are followed by a row of others which conceal the first and so three, four or more rows are applied, the last row of sutures uniting the peritoneal surfaces and alone showing whence the tumour came. In fibroids which develop deep along the sides of the uterus, and push up the Fallopian tube and ovary it may not be possible to spare the organs. But even in such cases he spares the uterus and its appendages as much as possible. In case there is no pedicle around which to place the rubber band, he forms one in the following manner: he severs the appendages by first double-ligaturing the broad ligament with its spermatic vessels, and dividing between these ligatures. The process is

repeated with the round ligament. After this it is easy to separate the tumour from its attachments to some extent, without much hemorrhage. The rubber ligature is now applied tightly around its base. The tumour is then cut off. The stump must be caught by a vulsellum as soon as it is partly divided, otherwise the rubber ligature will be apt to to slip off. The opened cavity of the uterus, or cervical canal, is now cauterized with a 10 per cent. solution of carbolic acid to destroy infections germs that may be present. The stump or wound is treated as in the previous instance by successive rows of silk sutures, the last row uniting the peritoneum only. Prof. Schroeder believes that it will thus be possible to remove by enucleation and with the India-rubber ligature any fibroid, if there be an urgent indication justifying the operation. He has operated on 66 patients and lost 20 (30 per cent.); of the last 40 cases, however, only 9 (22.5 per cent.) have died; and he ascribes these improved results to having operated by his method above described (India-rubber ligature, method of suturing, and enucleation.)

Sir Spencer Wells agreed generally with Mr. Thornton's opinions as to the limitation of operations on uterine fibro-myomata. As regards Schröder's methods, he thought that the large drainage tubes might lead to sepsis, and that accumulations of fluids might take place between the rows of sutures.

Dr. Wallace, of Liverpool, urged a greater attention to other than operative treatment. It certainly sometimes caused involution of the tumour. He believed that hemorrhage could nearly always be controlled, he had never seen a patient die of hemorrhage from fibro-myoma.

Dr. More Madden, Dublin, deprecated the excessive, (as he believed,) tendency to operate. From his experience he believed hemorrhage could be arrested, and the patient kept alive for many years.

Dr. Graily Hewitt, London, had seen many cases in which the tumours had disappeared under treatment. He thought enough attention had not been paid to this. (*Brit. Med. Jour.*)

The American Gynecological Society met this year in Phila-

delphia under the presidency of the veteran and venerable ovariotomist Gilman Kimball, of Lowell. Several important subjects were under discussion. The limits of this report do not permit of more than an abstract of the most important.

Dr. R. S. Sutton, of Pittsburgh, read a paper on *Cleanliness after Surgical Operations.* He gave results of observations he had made while on a recent visit to some of the great clinics of Europe. He directed attention to the fact that a great change had taken place in surgical methods, and that this is especially evident in the great attention to cleanliness during surgical operations and in the treatment of wounds. The object of Lister's treatment is to keep out germs of organisms found in putrid discharges, and to maintain cleanliness. The result is that surgery is more successful than ever before, and yet the most active opponents of Lister are those who adopt his principles of treatment, omitting the spray or using some substitute for carbolic acid. Strict attention to cleanliness in all the details of the operation and keeping the wounds aseptic are the great principles of Mr. Lister's treatment. Keith is such an expert in cleanliness that he can dispense with carbolic acid. Tait uses the greatest care in securing cleanliness of everybody and everything connected with his operations, so that he can dispense with carbolic acid. These two operators use no disinfectant or germicide yet their results are better than those of any other living operators. German surgery used to be considered extremely dirty, now, a visit to the operating rooms of Esmarch, Volkmann, Schröder, Nussbaum, Koeberle and others, will show the most minute attention to cleanliness, although various minor modifications of the Lister treatment have been made.

Dr. Emmet said he had already expressed the opinion that too often a woman's death-warrant is carried under the fingernail of the surgeon. Since he had been abroad he had trusted to soap and water in preference to other antiseptics. An operator might keep himself clean, but it is very difficult to control his assistants.

Dr. Lusk uses the spray and believes that the dangers from carbolic acid have been exaggerated.

Hot Water in Secondary Hemorrhage after Pelvic Operations.—This was the title of a paper by Dr. Albert Smith, of Philadelphia. He advocated strongly the hemostatic properties of a stream of hot water in the cases mentioned, and to prevent post-partum hemorrhage by using it immediately after the expulsion of the placenta. He had found that hot water would check hemorrhage even in the hemorrhagic diathesis. He made the following points: (1) The great superiority of the hot water douche over all other means of arresting hemorrhage; (2) its efficiency when carried directly to the bleeding surface; and (3) its simplicity. Drs. Reamy, H. P. C. Wilson, Campbell, Mann, Goodell, Barker, and Byford took part in the discussion and in the main agreed with the reader of the paper. Dr. Goodell thought the action of the hot water was remote as well as local, as witness its effects in checking menorrhagia when injected within the vagina. He thought hot water especially useful to check oozing in ovariotomy. For open wounds he preferred vinegar; for post-partum hemorrhage he preferred hot vinegar.

Dr. C. O. Palmer, of Cincinnati, selected: "Some Points connected with Dysmenorrhœa," as the subject of his paper. He remarked upon the frequency of the affection and its troublesome nature to treat. After reviewing briefly the mechanical theories of Macintosh, Simpson and Sims he stated that undoubtedly obstructions do exist and give rise to painful menstruation, but he believed this to be comparatively rare. There are three principal objections to the mechanical theory:

(1). A want of uniformity between the cause and effect, the same amount of obstruction giving rise to different symptoms in different cases. There may be the most severe symptoms attendant on the condition of a cervical canal which at the moment of pain admits the passage of an ordinary sound.

(2). Constitutional treatment is more effective than local measures, iron-tonics and agents that increase the flow of blood relieve the pain.

(3). The course of the menstrual blood may be as uninterrupted in a curved uterine canal as a straight one.

Congenital flexions are generally attended by dysmenorrhœa, but similar conditions acquired in adult life are rare.

The last two points express conclusions recently published by Dr. John Williams and Dr. Ernest Herman, of London, independently of each other.

Reference was made to the extreme sensitiveness of the uterus, at or above the os interumn, when the sound is passed, in this disease. The sensory nerves of the uterus are in a state of hyperæsthesia or neuralgia. Sometimes clots may thus act as irritants to the lining membrane, but it is quite clear that they do not always do so. Dysmenorrhœa he thus believed to be in the great majority of cases a functional disorder of the uterus. It is essentially and in its underlying nature a neurosis. It has many features in common with other visceral neuralgiæ. Such persons are usually emotional, sensitive, and impressionable. The local neurosis is an expression of an impaired, disordered, or highly developed nervous system. Imperfect general development predisposes to this neurotic habit, and so do imperfect sexual developments. True obstructive dysmenorrhœa, while it exists, is certainly very rare.

Treatment ought at first to be general in all young unmarried women. He thought local examination and treatmcnt to be very reprehensible in all such cases until constitutional treatment had had a fair trial. In the intervals attention should be given to all means that improve general health. Iron and arsenic—galvanism to the hypogastric plexus and spinal centre sometimes does much good. He had seen decided benefit from prolonged administration of potassic iodide and mercuric bichloride in small doses. It was not in syphilis or in peri-uterine inflammation, but the only lesion was a chronic endometritis and the pain was spasmodic. He had confidence in cimicifuga and pulsatilla given during the attack. He condemned morphia, which never cures but does great harm to the nervous system. Dilatation by sounds and bougies often relieves stubborn cases, not as a rule by securing a larger canal, but by blunting the sensibility of the uterus, and stretching the irritable fibres of the internal sphincter. Stenosis is more frequent at the os tincæ than else-

where and this explains the greater frequency of sterility than dysmenorrhœa. Stenosis, if not a potent factor in causing sterility, is a most important cause of chronic disease of the uterus —dilatation of the cavity, thickening, softening and granular degeneration of the endometrium—consequently stubborn catarrh. In such cases he thought it better to incise than dilate.

Dr. Chadwick, of Boston, agreed with most of the author's statements. He had given up the theory of obstruction, and never incised except at the external os. Before the period for a week he uses bromides in 10 to 20-grain doses, so as to blunt to some extent the sensibilities. During the period he uses coca and carbonate of ammonia, never morphia.

Dr. Barker, of New York, shared the opinion of the author as to the rarity of obstruction as a cause of dysmenorrhœa. Ho believed in two sorts of pain; uterine and ovarian. As a tonic he preferred lactate of iron which he combined with chlorate of potash. Apiol had yielded him very good results. His method of administration is to begin two days before the menstrual period by giving it in capsule after meal and continuing it during the period. In cases of ovarian excitment without discharge he gives bromide of sodium in 10 to 15-grain doses. He believes it is less apt to cause the skin-eruption than the potassium bromide.

Dr. T. A. Emmet, of New York, read a paper on "A Study of the Etiology of Perineal Laceration, with a new Method for its Proper Repair." The author affirmed that he had for years paid considerable attention to the subject of perineal lacerations. The suffering ascribed to laceration of the perineum is not proportionate to the extent of the lesion, and as everybody knows some of the severest cases are unaccompanied by symptoms. He directed attention to the anatomy of the pelvic fascia showing its attachment to the pelvic organs, and to the inlet of the pelvis, and declared that these organs are held in place by this fascia, which is continued downwards as a sheath for the vagina. During labour this fascia may be injured or lacerated: when this condition occurs, perineal laceration often follows during the descent of the head and shoulders of a child. Even in

cases without external laceration, relaxation of the vagina occurs and the posterior wall falls away from the anterior one. This rolling out of the mouth of the vagina, as if the drawing string had been broken, exaggerates the appearance of laceration of the perineum, making it seem more extensive and important than it really is. The operation which he proposed had for its object the shortening of the posterior wall of the vagina, so as to restore to it its relation to the anterior wall. This object is attained by making two crescentic lines of denudation transversely across the vagina, and uniting them by a line of sutures which after the operation are hidden entirely within the vagina. The result is that the perineum is drawn upward towards the pubes, and any laceration existing in it may be disregarded, or it may be united by an interrupted suture. He maintained that we might leave out of consideration, in performing the operation, everything in regard to the external organs outside the line of the hymen. His object was to call special attention to the rôle which the fascia plays in supporting the pelvic organs, and to the fact that the lacerated perineum has little or nothing to do with the symptoms complained of. The discussion shewed that either Dr. Emmet had not made himself perfectly understood or had not convinced the Fellows of the truth of the new doctrine he was endeavouring to promulgate.

Dr. Frank P. Foster, however, agreed with Dr. Emmet when he said that the perineum does not support the uterus, when the parts are normal. The perineum, however, has a function, it serves as a *point d'appui* for a number of muscles.

Dr. R. S. Sutton disagreed with Dr. Emmet. He believed in the perineal body which could be demonstrated in frozen sections. Dr. T. G. Thomas had said that it is better for a woman to break her leg than rupture her perineum, and he (Dr. S.) agreed with him. He, however, admitted that there are many cases that do not require surgical aid. For superficial lacerations he believed that the operation proposed will restore the parts, but when the laceration has extended through the perineal centre he cannot believe it.

Dr. A. Reeves Jackson read a paper entitled, "Is Extirpa-

tion of the Cancerous Uterus a Justifiable Operation ?" He said, " In medical and surgical practice the results obtained from any means or method of treatment are proper tests by which their value may be judged." Tried by such tests, he believed this operation to be found wanting. Whenever a therapentic agent has been found after adequate trial to generally fail in effecting the purpose of its use or to be habitually dangerous to life, candid and honest men have ceased to employ it." He deprecated the rapidly growing tendency to a bold, fearless, even reckless progressiveness in surgery. He said it is notorious that in almost all instances in which surgical operations have been done for the removal of cancers, they have only been of temporary benefit—if beneficial at all. However, when these were free from danger to life, so long as they did no actual harm, they were doubtless proper in many instances, because they added for a time to the patients' comfort. They rarely did more than this. But when the operations themselves become so dangerous as to destroy 70 per cent. of lives within a few hours, or a few days; and when, of the few who escape the operation, 50 to 75 per cent. die from recurrence of the disease within a few months; and when, further, of those who yet remain, all, or nearly all die, as soon as though no operation had been performed, we should halt to consider whether our calling thus exercised is beneficial or injurious.

By Freund's abdominal method the mortality is frightful. By the latest table of 91 cases—66 died; 25 recovered. Czerny, Schroeder, Martin and others have operated extensively by the vagina with much better results. Sänger's table of 143 cases, published in the *Archiv. f. Gyn.*, 1883, shows recoveries, 72 per cent. ; deaths, 28 per cent.

Dr. Jackson then stated that in his opinion extirpation of the uterus does not save, but destroys life. " In order to show how much life has been sacrificed by it, I accept all the known fatal operations as the full number, although it is certain that there are many more. They amonnt to 159 cases—97 abdominal and 60 vaginal. If we grant that in all these cases the disease affected the cervix, and that the average length of life is

seventeen months, the calculation would show more than 222 years of life—over two centuries—sacrificed by the operation. If we consider that in many of the cases the disease affected the corpus uteri, as it surely did, in which the average duration of life is 2½ years, the aggregate amount of life destroyed would be even greater.

He summarized as follows:

1. Diagnosis of uterine cancer cannot be made sufficiently early to ensure its complete removal by extirpation of the uterus.

2. When the diagnosis can be established, there is no reasonable hope for its radical cure; and other methods of treatment, far less dangerous than excision of the entire organ are equally effectual in ameliorating suffering, retarding the progress of the disease, and prolonging life.

3. Extirpation of the cancerous uterus is a highly dangerous operation, and neither lessens suffering—except in those whom it kills—nor gives reasonable promise of permanent cure in those who recover. Hence, it fails in all the essentials of a beneficial operative procedure, and should not be adopted in modern surgery.

Dr. Van de Warker said, he took substantially the same ground as that held by Dr. Jackson. He operated by removing all the diseased tissue by scraping out. He then used Monsell's solution of subsulphate of iron to check bleeding. Subsequently the hollowed out cervix is packed with cotton soaked in a saturated solution of chloride of zinc; the result is an enormous slough of the cavity of the uterus. He exhibited a number of sloughs that were removed in this way. One of the specimens had been removed 18 months ago, and the woman was still well.

Dr. Emmet, of New York, was much pleased with the paper because it expressed his own views with reference to the operation. His experience is confined to one case and that was unsuccessful. It was done through the abdominal incision. If the operation is ever to be done, it should be done by the vagina, and should be confined to removing the uterus for sarcoma.

Dr. Baker, of Boston, described his operation for removing the entire supra- and infra-vaginal portions of the cervix as well

as from one-third to one-half of the body of the uterus. He has operated at least 30 times without a single death, and he can recall six cases, of at least 9 years standing, which have absolutely recovered. The cases in which total extirpation of the uterus is advisable are extremely rare, and comprise those in which the disease begins in the cavity of the uterus.

Dr. C. D. Palmer, of Cincinnati, said that so far as total extirpation of the uterus for cancer is concerned, the cases belong to one or other of two classes: 1. Those in which it is clearly unjustifiable. 2. Those in which it may be justifiable. The first would include almost every case of cancerous disease beginning in the cervix. The second would include those cases of sarcoma starting in the uterine body, which are very rare. It is usually impossible to determine whether the disease has extended beyond the uterus itself.

Dr. Sutton, in speaking of the removal of the uterus per vaginam, said it is not so fatal as ordinary ovariotomy. Schröder lost only one out of thirteen from the operation, and Martin had told him that his longest case lived twenty-two months after the operation.

Dr. Sutton then described the operation as performed in Europe. The patient is placed in the lithotomy position, and Simon's speculum is used to elevate the anterior vaginal wall and depress the posterior. Lateral retractors are also used. In order to prevent the constant presence of blood in the vagina, a stream of carbolized water is thrown in. An incision is made across the cervix, just below the vaginal attachment. A curved needle is then passed through the upper lip of the incision and the ends drawn out together and turned over the pubes. With the thumb nail everything above the cellular tissue is skinned back until the perineum between the bladder and the uterus is reached. The incision is then carried across the neck. The posterior lip is next treated in the same way. The peritoneum is then opened and the opening dilated with the finger. A volsellum forceps is next passed through the opening grasping the fundus and drawing it into the vagina. With a curved needle a double ligature is passed through the broad ligament and firmly tied.

A clamp forceps is applied to the ligament, and it is then cut. The uterus is then drawn down and the ligament on the opposite side treated in the same way. The opening in the vault of the vagina is not sewed up. Schröder puts a large drainage-tube into the pelvic cavity, one end of the tube being outside of the vulva.

The vagina is then packed with cotton saturated with iodoform. Martin sometimes simply stuffs the vagina with antiseptic material, and the patients recover. So far as the advisability of the operation is concerned, he had not made up his mind.—(*Medical News*, Philadelphia; *Philadelphia Medical Times*, September, 1883).

Reviews and Notices of Books.

A Treatise on the Diseases of the Eye.—By J. SOELBERG WELLS, F.R.C.S. Fourth American from the third English edition, with copious additions by CHAS. STEDMAN BULL, A.M., M.D., Lecturer on Ophthalmology in Bellevue Hospital Medical College, Surgeon to the New York Eye Infirmary, &c. Illustrated with 257 engravings on wood and six colored plates; 816 pages. Philadelphia: Henry C. Lea's Son & Co.; Montreal: Dawson Bros.

Anyone desirous of obtaining the most complete work on diseases of the eye in the English language will find in this treatise the fulfilment of that desire. The original work, by the late lamented J. Soelberg Wells, has for so many years held the front rank as a standard authority on ophthalmology that nothing more requires to be said in its favor except that the book is to the present generation what that of Mackenzie was to the past. Mr. Wells still lives in the memories of those who had the privilege of knowing him personally as a genial and kind-hearted man, a courteous and polished gentleman, a skillful practitioner of his art, and an accomplished scholar, and it is a pleasing circumstance that the perpetuation of his great work has fallen to the lot of one so well qualified for the task as the present editor, Dr. Chas. S. Bull, who, in addition to being already well known for his original work, scientific and clinical, has a thorough knowledge of ophthalmic literature, such as can only be attained by

those who are familiar with the most important modern languages. The book, as edited by Dr. Bull, although containing only a few pages more than the third English edition, is more closely printed, and in reality one-fifth longer as to reading matter. This addition to the size of the volume is caused by the numerous paragraphs inserted by the editor in order to bring the work up to date, and may be taken as a brief, but very excellent, *resumé* of the progress made in ophthalmology during the past ten years. The editor has been singularly happy in following the style of his author, and the whole is so harmoniously combined as to read like the writing of one man. It is no exaggeration to say that there are few more readable books in medicine than this; certainly no medical library can be considered complete without it.

Excision of the Knee-Joint, with report of 28 cases. Illustrated by 13 photo-lithographs and wood engravings. By GEO. EDGEWORTH FENWICK, M.D., C.M., Professor of Surgery, McGill University; Surgeon to the Montreal General Hospital. Montreal: Dawson Bros.

The subject of excision of the knee for disease and other conditions affecting the usefulness of the limb is one to which Dr. Fenwick has devoted a great deal of attention. His results have been eminently satisfactory and encouraging, so much so that he is anxious to assist in dispelling any doubts that may have arisen as to the value of the operation. This monograph consists of two parts. The first gives an account of the operation as first devised and practiced, and its standing and procedure at the present day as judged by the most recent writings of eminent surgeons. This section also includes the author's remarks upon the character of the cases which he considers suitable for excision, the various modes of after-dressing, and the appliances therefor, with illustrations of those which he has found to answer best. Some modifications in the operation—notably the rounded section of the bones—are peculiar to Dr. Fenwick himself, and the latter, in his opinion, has proved a decided improvement. The second section gives detailed reports, with a table, of his series of cases. Some of these have already been published, but are now re-introduced with later cases in order to complete

the entire number. We take much pleasure in introducing this book to our readers, many of whom are counted amongst the author's numerous friends and former pupils. It is an excellent and practical contribution upon an important subject, based upon the personal experience and careful observations of one who has long deservedly held a prominent place amongst Canadian surgeons. It is nicely printed, and the lithographs are excellent.

Gout in its Protean Aspects.—By J. MILNER FOTHERGILL, M.D., M.R.C.P., Lond., Physician to the City of London Hospital for Diseases of the Chest; Hon. M.D., Rush College, Chicago, &c. Detroit, Mich.: George S. Davis. 8vo.; pp. 300.

Dr. Fothergill is well known as one of the prolific writers of the present day, and his physiological attainments and therapeutical researches render him peculiarly well fitted for the production of such a treatise as the present. The disease, gout, to which the greater part of it is devoted, is, fortunately (for the public), a very rare affection in this country. Its study, therefore, does not command the same attention from the practitioner here as elsewhere. Still, it is one of the constitutional disorders which, from its interesting pathology, far-reaching complications and often obscure symptoms, will always be studied with renewed zest by the scientific physician. Special consideration is given by the writer to the subject of the nervous manifestations of gout, as these special disorders are said to have been becoming of late years more common than the more pronounced and acute inflammatory attacks. The recent views on the pathology are all worked out, and chapters are given on the diagnosis, etiology, prognosis and treatment. The pleasant mode of writing of this author renders the book uncommonly readable, whilst the whole shows considerable originality and careful observation. Dr. Fothergill is the arch-enemy of the nihilists in therapeutics who so predominate at the present day, and on this account alone his book is worth reading and having students read. Even in connection with so-called rheumatic gout (*arthritis deformans*), that hopeless-looking complaint, Dr. F. would by no means admit the pessimist view so commonly taken by writers. He would,

on the contrary, insist upon patient examination of an early case, with the object of determining, if possible, the general systemic fault which is likely to be present, and upon persevering efforts to remove this by climate, natural waters, internal medication, local means, &c., and declares that, even in unpromising cases, our efforts will not unfrequently be rewarded by a fair share of success. He concludes by a short chapter on Chronic Rheumatism, and one on "Some general considerations on Indigestion, Biliousness, Diabetes and Gout."

The Untoward Effects of Drugs: A Pharmacological and Clinical Manual.—By Dr. L. LEWIN, Docent of Materia Medica, Hygiene and Public Health in the University of Berlin. Second edition, revised and enlarged. Translated by J. J. MULHERON, M.D., Professor of Principles of Medicine, Materia Medica and Therapeutics in the Michigan College of Medicine, Detroit, Michigan. George S. Davis, Detroit Mich.

In teaching or learning the symptomatology of disease, it is necessary to teach or learn from cases taken as types of each separate group of diseases: but the student soon finds that, in the great majority of cases, the type has to be sought for amongst many casual conditions which may at first sight appear not to belong to it at all. These are to be obtained chiefly by experience. So with a knowledge of drugs. The teacher describes, and the student comes to know, the recognized actions to be expected from the exhibition of a certain drug. When, however, that drug is given, certain other results may be observed which are unexpected, or unusual, and may, perhaps, be attributed to some other cause, when, in reality, they were effects proper of the drug in question. Again, there are many drugs whose special action in disease it may often be extremely desirable to procure, and yet they possess as well the property of affecting, in some unwished-for manner, certain other functions or organs. For many reasons, therefore, it is important for the advanced student in therapeutics and for the practical physician to have some sort of reference to which he may go for the explanation of these points. Many of the facts to be found in this book are already fully recognized in the text-books of Materia Medica,

but a multitude of details and valuable information in connection with these points only exists scattered through the periodical literature of many years past. This book collects all these in a systematic form, and presents them in such a way that anything sought for can be found under its appropriate heading. Numerous references also are given, when important drugs are discussed, so that one interested in the matter can refer to the original articles. Thus, any one observing what is apparently an effect of a drug of an unusual character can at once here ascertain what the most recent authorities have to say on that particular subject. The scope of the work, it will thus be seen, is somewhat original, and the object of the author has been thoroughly worked out. We have no doubt that this book will be largely availed of throughout the profession and by many of our senior students.

A Pocket-Book of Physical Diagnosis of the Diseases of the Heart and Lungs, for the Student and Physician.—By DR. EDWARD T. BRUEN, Demonstrator of Clinical Medicine in the University of Pennsylvania, and Assistant Physician to University Hospital, &c. Second edition; revised, with additional illustrations. Philadelphia: P. Blakiston, Son & Co.; Montreal, Dawson Bros.

A concise and practical exposition of the physical signs of the organs of the thorax, normal and diseased. The descriptions are made very intelligible, and a feature of the little book consists in the introduction of a number of original drawings from actual cases, which serve to impress the reader more particularly with the points under consideration. We can recommend it specially to advanced students, to assist in their studies and for reference at the bedside.

The Practitioner's Ready Reference-Book: A handy Guide in Office and Bedside Practice.—By RICHARD J. DUNGLISON, A.M., M.D., author of "A New School Physiology," "Medical Dictionary," &c. Third edition, thoroughly revised and enlarged. Philadelphia: P. Blakiston, Son & Co.

We have already had occasion to notice most favorably the

earlier editions of this useful book. This, now the third, comes to us very considerably enlarged, and containing a good deal of new matter, all of which is quite appropriate, and certainly adds to its value. From a long list of the specialties, to which we are now introduced for the first time, we make the following selection, which will serve to show the wide range of subjects covered, viz., Nutritive Enemata (new formulæ); How to apply Bandages; Treatment of foreign bodies in the Eye and Ear; Treatment of Frost-bite, Sprains, Spitting of Blood, Insensibility, Suffocation, and Sunstroke; How to make Poultices; Vapor Baths; How to lift helpless patients; The collection of dates at, and how to preserve the record of, Autopsies. To every practitioner it will be useful; to every young practitioner it will prove a mine of practical hints to serve him in all emergencies, and to help him in all the minor details of practice to which he is yet a stranger.

Transfusion: Its History, Indications, and Modes of Application.—By CHARLES E. JENNINGS, L.R.C.P., Lond., Fellow of the Obstetrical Society of London, &c. With engravings and a bibliographical index. London: Baillière, Tindall & Cox.

This is a book of small dimensions—in fact, so small that the author begins by making excuses for it. He "feels himself in the position of that Greek nobleman who, having invited a number of distinguished guests to attend the funeral of his infant daughter, apologized for bringing so small a corpse before so august an assembly." In reality, however, it requires no apology, for it contains much that is valuable and interesting concerning an operation which, though seldom called for, is still sometimes the only means by which life can be saved. The scope of the monograph is clearly enough indicated by its title. Few persons have had much experience in transfusion, and anyone about to operate will do well to study Mr. Jennings' remarks thereon, as he will find many hints which will serve to obviate practical difficulties standing in the way of its successful accomplishment. The woodcuts illustrate the author's syphon for intravenous injection and immediate transfusion.

Books and Pamphlets Received.

CRUISE OF THE REVENUE-STEAMER CORWIN IN ALASKA AND THE N. W. ARCTIC OCEAN IN 1881. Notes and Memoranda: Medical and Anthropological; Botanical; Ornithological. Washington: Government Printing Office.

THE TREATMENT OF WOUNDS: ITS PRINCIPLES AND PRACTICE, GENERAL AND SPECIAL. By Lewis S. Pilcher, A.M., M.D. New York: William Wood & Co.

TYPES OF INSANITY: AN ILLUSTRATED GUIDE IN THE PHYSICAL DIAGNOSIS OF MENTAL DISEASES. By Allan McLane Hamilton, M.D. New York: Wm. Wood & Co.

THE MEDICAL STUDENT'S MANUAL OF CHEMISTRY. By R. A. Witthaus, A.M., M.D. New York: Wm. Wood & Co.

A PRACTICAL TREATISE ON THE MEDICAL AND SURGICAL USES OF ELECTRICITY, including Localized and General Faradization; Localized and Central Galvanization; Franklinization; Electrolysis and Galvano-Cautery. By G. M. Beard, A.M., M.D., and A. D. Rockwell, A.M., M.D. Fourth edition. New York: Wm. Wood & Co.

A MANUAL OF PATHOLOGY. By Joseph Coats, M.D. With 339 illustrations. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Brothers.

CHEMISTRY: GENERAL, MEDICAL, AND PHARMACEUTICAL; including the Chemistry of the U.S. Pharmacopœia. A Manual of the General Principles of the Science and their applications in Medicine and Pharmacy. By John Attfield, F.R.S. Tenth edition. Specially revised by the author for America. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Bros.

THE COLLECTIVE INVESTIGATION OF DIPHTHERIA AS CONDUCTED BY THE THERAPEUTIC GAZETTE, DETROIT, MICH. With Editorial Summary. By J. J. Mulheron, M.D. Detroit, Mich.: George S. Davis.

THE TREATMENT OF WOUNDS AS BASED ON EVOLUTIONARY LAWS. By C. Pitfield Mitchell. New York: J. H. Vail & Co.

THE PATHOLOGY AND TREATMENT OF VENEREAL DISEASES. By Freeman J. Bumstead, M.D., LL.D., and Robert W. Taylor, A.M., M.D. Fifth edition, revised and rewritten, with many additions, by Dr. Taylor. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Bros.

CHEMISTRY, INORGANIC AND ORGANIC, WITH EXPERIMENTS. By Charles Loudon Bloxam. From the fifth and revised English edition. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Bros.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, September 21st, 1883.

R. A., KENNEDY, M.D., PRESIDENT, IN THE CHAIR.

Dr. Trenholme exhibited the ovaries and tubes which he had removed three weeks ago from a patient, 24 years of age. She had suffered from dysmenorrhœa, with pain continuing after the period, making life miserable. The ovaries were removed by abdominal section under the spray. Both were hypertrophied

and tubes congested, there was also congestion of the uterus. Patient made a perfect recovery.

Dr. Trenholme also shewed an ovarian tumor removed by him thirteen days ago. Patient was 24 years of age. Was sent to him from the country. Had suffered for four years, distress gradually increasing, but tumor had been only recently discovered. Dr. T. found a large tumor to the left of median line, and diagnosed cyst of left ovary. On opening the abdominal cavity and examining, was found to spring from the right ovary, and weighed twelve pounds. Patient did well; highest temperature was on 8th day, 100.2°, from a slight bilious attack. Dr. Young gave the following description:

Right ovary expanded by pressure, yet apparently healthy, as proved by the normal condition of the ova, which are shown as coming to maturity. There are three cysts, the covering of each being continuous with the covering of the ovary; they are all extra-ovarian, *i.e.*, the tissues of the ovary are not involved in their development, but the capsule of the ovary constitutes the covering of the cyst. Each cyst contained serous fluid, and on the wall nearest the ovary a small *sac* containing a grumous yellow mass was found, suggesting the possibility of the retention of the *ova* in the covering of the ovary as giving rise to inflammatory action in the middle cyst. Exactly over this yellow pigmentary deposit was a *warty* fibrous excrescence, which also favors the idea of irritation from non-escaped ova being the cause of the cystic development. The left ovary is much enlarged; covering dense, otherwise healthy.

Dr. Henry Howard wanted to know if Dr. Trenholme only performed "Tait's" operation as a *dernier ressort*—that is, after trying other means for relieving the symptoms—as he thought there might be a danger now-a-days of resorting to spaying without a fair trial of less heroic treatment.

Dr. Fenwick read a paper on *Ligature of the Axillary Artery in a case of traumatic injury to that vessel after fracture of the surgical neck of the humerus.* The following are the principal points in the case:

Eliza C. B., aged 41, a spare, delicate-looking woman, was admitted into the Montreal General Hospital, on May 30th,

1883. While walking in the street a piece of heavy timber fell from a building; it broke in two, and the upper half struck her on the shoulder, breaking the humerus at its upper third, about two inches below the joint; the upper fragment was drawn forcibly inwards, and lacerated the brachial artery at or about the point of the commencement of that vessel. On examination, the shoulder was greatly swollen, the axillary pit brawny, and filled with what appeared to be blood; there was considerable tumefaction beneath the pectoral muscle, extending as high as the clavicle. The entire upper part of the front of the chest and axilla was tense and mottled; there was absence of pulsation below. On examination with the stethoscope, the pulsation could be traced down to a point about an inch below the fold of the axilla, and at this point there existed a circular abraded surface about the size of a shilling. This was situated over the position of the artery, and below this point all evidence of arterial pulsation ceased. The forearm and hand were greatly congested, the vein distended almost to bursting, the color of the skin was dark and mottled, the limb cold, the temperature being below the normal standard. A consultation of the surgical staff was hastily summoned, and in the meantime the limb was supported on a pillow, and hot flannels applied to restore warmth and favor the circulation. In consultation it was suggested to make an exploratory incision over the course of the vessel, ligate it above and below the point of injury, and turn out as much of the blood-clot as possible to relieve tension and endeavor to save the arm. During the two hours which had elapsed the same state of things existed, if anything in an aggravated form, the superficial stasis and coldness of the limb had extended, and the swelling had increased; the pulse, which at the former visit was moderately full and 80 per minute, had become more rapid and somewhat weaker, and there was perfect absence of sensation as high as the middle of the arm. The patient was placed under ether, the subclavian artery was compressed with the handle of a door-key, where it passes over the first rib. The arm being by the side, an incision three inches in length was carried down directly over the situation of the artery; the centre of the incision being at the point where pulsation had

ceased, as ascertained by the stethoscope. A large blood-clot was removed, and the artery and median nerve hooked upon the finger; the wound in the vessel was quite apparent, and carbolized catgut ligatures were applied above and below the injury. The upper ligature was applied at the point where the vessel passes over the tendons of the teres major and latissimus dorsi muscles, which were quite visible. As much of the blood-clot as possible, without disturbance of the parts, was pressed out. The injury to the bone was a simple transverse fracture; the upper fragment was lying in front, and drawn inwards; the lower fragment was drawn upwards and outwards, and there was shortening of about an inch and a half. Extension of the limb brought the fragments near together, and, by a little manipulation, the broken ends were accurately adjusted. The wound was cleansed with a warm solution of 1 to 40 of carbolic acid, the wound closed with catgut sutures, and dressed with the usual antiseptic dressing; outside of the dressing, two pieces of Gooch's splinting were fitted, and retained in position by a couple of bands of ordinary bandage, and the hand and forearm swathed in a flannel bandage. The operation was performed under the spray, and with full antiseptic precautions. There was one circumstance which was noticeable at the time of the adjustment of the fragments—a large clot was liberated and came away, and the veins, which previously were flaccid and empty, at once became distended, and the stasis in the forearm and hand was relieved. Before applying the flannel bandage the parts had assumed a more natural hue. At night she was very comfortable; there had been considerable draining away of serum tinged with blood; the color of the forearm and hand was natural, and the warmth of the limb appeared to be that of the rest of the body; there was, however, no pulsation to be felt at the wrist.

May 31*st.*—She had passed a fairly good night, had slept at intervals, and had taken nourishment in small quantity, principally milk. The evening temperature was 101°, and had fallen to 99.2° in the morning. There was no pulsation at the wrist. Very little discharge had escaped since night, except bloody serum, which had apparently dried, so that I did not disturb the limb by changing the dressing.

June 1*st*, 1 *p.m.*—I dressed the arm to-day ; the wound was looking well ; discharge trifling, and of the same character. The fullness about the front of the chest beneath the clavicle had greatly lessened. The same dressing was applied. On careful examination, the pulse was distinct at the wrist, though small in volume as compared with the opposite arm. This was forty-five hours since the ligation of the vessel, and about forty-eight since the accident.

From this time forward she progressed slowly, but favorably ; the wound closed, and union between the broken fragments of bone took place, and the patient left the hospital towards the end of July.

Dr. Fenwick said :—This was a case of unusual occurrence, and is of interest in illustration of the surgical principle of ligating a vessel at the point of injury. There are other conditions connected with the case which might render this line of practice objectionable, and to which exception might be taken, as the converting a simple into a compound fracture. The case was desperate, and one of two things had to be done : either ligate the vessel, and endeavor to save the arm, or practise amputation at the shoulder joint. The conversion of a simple into a compound fracture, always a serious injury, and to be avoided if possible, is less feared now, with the use of antiseptic means, which, in this instance, were fully carried out. A most interesting circumstance connected with this case was the accuracy with which we were enabled to ascertain the actual point of injury to the vessel by the use of the stethoscope ; the humming of the artery could be distinctly made out to cease at a given point, opposite to which was an abraded portion of skin and exactly at this point the wound in the vessel was found. Another point of interest was the return of the radial pulse forty-five hours after ligation of the vessel.

Dr. Hingston approved of Dr. F.'s treatment of the case, and thought that no alternative should have presented itself but to cut down to the middle of the surface and ligate the vessel.

Dr. Shepherd, who assisted Dr. Fenwick, said that why they thought of amputating was because of the condition of the

and that our secretary will not find it so difficult to obtain papers in future. Several of the papers have been hurriedly prepared to fill the want, otherwise fewer meetings would have been held. One very valuable one was by Dr. Osler and Mr. Clement on Parasites in the Pork Supply of Montreal. To the meeting at which the paper was presented members of the Board of Health and other interested persons were invited. From a sanitary point of view it was specially valuable, and much credit is due to the gentlemen who had taken so much trouble in bringing it before you. I am afraid, however, that it has had but little influence in producing any result, so far as our sanitary authorities are concerned.

In addition to papers we have had interesting cases in practice related by several of our members which, in some instances, excited considerable discussion. Patients suffering from peculiar forms of disease have been shown by Drs. Hingston, Gurd and Wilkins, and a large number of pathological preparations exibited, chiefly by Dr. Osler—on whose labors in this line I need not dilate—and also by Drs. Ross, Bell, Shepherd, Wilkins, Alloway, Fenwick, Gardner and Trenholme. These preparations, though gratifying to our visual organs and instructive to our mental faculties, did not always invest our persons with the odor of sanctity. Among matters which may be termed miscellaneous may be mentioned the reporting of the proceedings of the Society by our medical journals, under the supervision of a publishing committee. This arrangement has worked fairly well, and has done much, I think, by giving due publicity to our work, in interesting country practitioners who, from their positions, are unable to become workers in any society; besides it furnishes a record which will be found useful to the future compiler of the medical history of the city. To our Secretaries we are indebted for the able manner in which they have performed their really arduous duties in this respect, and you have acknowledged this service when bidding adieu to the gentleman whom you elected to the office last year. Dr. Henderson proved himself an efficient worker whom we could ill afford to lose, but I am happy to state that in the new sphere of his labors he is meeting with that deserved success to which his merit entitled him. Though some familiar faces are not with us to-day, their work being elsewhere, new members have joined us, and keep up the number of our roll call. Rarely does a twelve months elapse without having the lesson exemplified "that in the midst of life we are in death." We have been called upon to mourn the loss of two old familiar friends; both ended lives of usefulness and industry at an advanced age. In their loss we

mourn no unfinished career, "cut untimely off,"—I allude to the death of Dr. David and of Dr. Scott. The former, once President, has left us a valuable record of the early history of medicine of this city in his reminiscences, which were read at a meeting of the Society shortly before his death ; and to those of us who knew him as an active member of the profession he will be remembered with that kindly respect which an upright and able life-work prompts us to feel. The latter will also long be remembered by those whose privilege it was to listen to his teaching which had extended over so many years.

Passing from these sad memories I recall to your recollection the pleasant meeting which was held during the last Xmas holidays. I was, unfortunately, unable to attend, but, from what I heard of it, the relaxation from graver matters, though it may not have advanced science, tended to promote harmony and goodfellowship and will, I hope, be followed by like meetings at similar seasons in future.

In conclusion, let me thank you for the courteous manner in which you have borne my deficiencies as Chairman. Circumstances over which I had no control prevented me from being present at more than ten meetings, but I have endeavored to fulfil the duties imposed on me, and, as a member, I shall ever take a deep interest in the work of the future.

The following officers were elected : President, Dr. Rodger ; 1st Vice-President, Dr. Cameron ; 2nd Vice-President, Dr. Osler ; Secretary, Dr. Gurd ; Treasurer, Dr. Molson ; Librarian, Dr. Foley.

Council—Drs. Ross, Campbell and Buller. Publishing Committee—Drs. Ross, Cameron, Osler and Kennedy.

Dr. Wood read a paper on "Treatment of Urethral Stricture."

Dr. Hingston took exception to Dr. Wood saying his case was cured, and thought he ought to examine him again, for even after years he had known them to relapse, especially when treated by dilating. In dilating we should not stop with No. 12, as 18 was more like the full size of the male urethra. Dr. H. said it was extraordinary how surgeons differed in their treatment of these cases : Otis strongly advocating internal urethrotomy with dilatation, while an eminent surgeon of Boston dilated the urethra so forcibly as to tear the stricture. This surgeon told Dr. H. that it was their practice at his hospital always to so treat stricture, and that the results were most satisfactory. All these methods were good, but the difficulty lay in

finding out which will suit your case best. At a meeting long since, he advocated internal urethrotomy as best for most cases, but now believes that ascertaining the size exactly before and behind the stricture, so as to dilate to the fullest, gives the most satisfaction. The tolerance of the urethra indicates which method to employ. Some being most intolerant, and, after passing of an instrument, are followed by high fever, and even death has resulted from simply using a bougie or catheter. One instance he knew of where the person dropped dead at once. Has noticed that French Canadians are very tolerant. Dilatation with division is the latest treatment, and the one now most used. There is no necessity for dividing if you can get through a No. 6 English. The two kinds of stricture most difficult to treat are the very small and very large. If calibre very much narrowed, he either gets in a piece of whale-bone and passes others by the side of it or else the pathfinder, and over it sends the urethrotome, and cures at once, by dividing. Believes division also best for slight stricture in a large urethra.

DR. WILKINS said, when treating cases in hospital, if found the calibre very much narrowed, he introduced a whale-bone probe, and then Otis' modification of Thompson's divulsor, and dilated to full extent, but often had sharp and troublesome fever follow. Lately has been well satisfied with gradual dilatation by means of Lister's sounds.

DR. SHEPHERD said he believed Dr. Wood's case to have been one of hypochondria, and that the man had inflamed his urethra by treating himself. Dr. Shepherd treats stricture by gradual dilatation, excepting the resiliant kinds which must be cut. He never knew a case of real stricture to be permanently cured. Has several times seen urethral fever follow the passage of a bougie. Has a patient now, who has fever follow each passage of bougie, and believes this to be a case for division.

DR. MCCONNELL criticised Dr. Wood's prescription, and said the fact was well established now that Liq. Potassæ and all mydriatics were incompatible.

DR. WOOD replied by saying that, if well diluted, Liq. Potassæ and the mydriatics would retain their virtues for a few days. The Liq. Potassæ in his mixture of hyoscyamus was well diluted,

and only enough at a time was made to last three or four days. Dr. W. was sure his patient had stricture, and that now he was cured.

DR. RODGER said he used gradual dilatation but often saw relapses.

DR. CAMPBELL was astonished at Dr. Shepherd saying he never knew of a permanent cure. Dr. C. knows of many gentlemen in this city whom he had treated twelve or fifteen years ago, and who are now fathers of families, and who have not been troubled with their strictures since.

DR. H. HOWARD suggested that, perhaps, the reason for their not having stricture, after being married might solve the riddle by shewing that the relapses spoken of by the members were nothing more than new attacks.

OTTAWA MEDICO-CHIRURGICAL SOCIETY.

This Society commenced its winter meetings on Friday, the 26th October. The President, Dr. Robillard, in the chair.

During routine business, the "card" of an enterprising local practitioner was exhibited, and caused much amusement. The custom of advertising as specialists in the diseases of certain viscera was also discussed and disapproved.

The paper of the evening was presented by Dr. H. P. Wright, upon "*London Hospital Work*," being an outline of his observations during a recent visit to that city. He sketched the methods of work in the various institutions, remarked upon the views held by many of the surgeons in their special lines, and gave the treatment adopted by many of the specialists. A Simpson's Traction Forceps was exhibited, an instrument which he considered very valuable as an aid to the obstetrician. At the conclusion, a lengthy discussion followed, and a hearty vote of thanks accorded for the valuable and interesting paper.

DR. GRANT related a case where a belladonna plaster over the epigastric region had cured a case of severe nausea and vomiting in early pregnancy.

The CHAIRMAN called the attention of the members to the health of the city and prevalence of enteric fever.

Dr. Powell was requested to prepare a paper for the next meeting on "*Complications of Enteric Fever.*"

CANADA

Medical and Surgical Journal.

MONTREAL, NOVEMBER, 1883.

THE STUDY OF ANATOMY.

The Provincial Legislature, at its last session, passed an Act to regulate the method of supplying our medical schools with subjects for purposes of dissection. The immediate reason for the passage of this Act was the occurrence of almost daily scandals during the past winter, owing to the body-snatching carried on in numerous parishes around this city. The sense of propriety of the entire community was outraged by this repeated desecration of graves and vaults, friends and relatives made loud complaints of the injury to which they were thus subjected, and the press teemed with allusions to the exciting topic and called upon the Government to see that steps were taken to put a stop to it. The "Anatomy Act" already in existence had proved quite inoperative and had been allowed to become a dead letter. Its provisions were essentially the same as the present one, but owing to the absence of a penal cause, it could never be enforced. Action on the part of the executive was clearly called for; they owed it to themselves and to the country to see that such a crying evil should be arrested. The subject was one which had been successfully legislated upon in other countries and it was a disgrace to our civilization that such a state of affairs should continue in our midst. After due consideration, therefore, and after having taken the advice of those best acquainted with the working of these laws elsewhere, the present Act was presented to the House and became law. It was received with great satisfaction by all the medical schools, and by the general public. We are not aware of any protests having been urged against its provisions during its passage through its various parliamentary stages. Quite recently, however, considerable stir has been created in this city and attention re-directed to the subject, owing to the action of certain of the authorities of some of our charitable institutions. The chief provision of the law is to the effect that every establishment which receives Government aid comes within the operation of

the Act; and it provides that, in the event of the death in such institution of a person without *bonâ fide* relatives who have claimed his body for burial, the Inspector of Anatomy shall be notified, and shall dispose of such body for educational purposes. Father Dowd, on behalf of the St. Patrick's Orphan Asylum and some of the directors of the Protestant House of Industry and Refuge, have opposed the working of the law in their respective establishments. The former, we are bound to say, has taken the only logical course, *i.e.*, has renounced the Government grant. Thus, then, the law no longer refers to the asylum mentioned. But a number of the governors of the House of Industry appear desirous of keeping the grant but evading the law. We regret very much this action on their part. The law is an absolutely necessary one in the interests of the peace of the whole community. They must know the scandals, the angry words and deeds, the heart-burnings, the police-court trials, the disgraceful traffic in bodies, that preceded the passing of this salutary Act. They must know all this. Now, the question is, do they wish to revert to that state of things? If not, will they please show us how a better arrangement could be made for supplying our dissecting rooms. They know these rooms *will* be supplied, legally if possible, illegally if not otherwise. The law guards carefully the disposition of the remains of those who have relatives—these have a natural right, no one can interfere with this. The remains of those who have no relatives, the waifs and strays, the law undertakes to dispose of, and in no other conceivable way can scandal be avoided and the reasonable demands of anatomical teachers complied with. We hope that the better counsels of some who addressed the meeting will yet prevail and that the opposition of this important body may be withdrawn. We would remind the gentlemen of the "House of Industry" that one of the greatest of our public charities has long faithfully submitted to the provisions of the old Anatomy Act, and, in not one single instance, has any dispute, scandal, or trouble arisen therein upon that score.

OUR PROVINCIAL LICENSE EXAMINATION.

Last month we took occasion to say something upon the present mode of conducting our Provincial Medical Board. Unseemly haste would appear to be the leading feature in the proceedings of that which should be a deliberative (and therefore necessarily deliberate) body. In nothing is this so marked as in the way in which the examination of candidates for the license is got through with. The instant the few short minutes

allowed by law for this purpose are at an end, a hurried conference of the examiners is held and a verbal report of the result conveyed to the President. There is a section of the law which reads: "Each member of these sub-committees (examiners) shall * * * * register his vote *with his initials* immediately after the examination." This is a very proper provision, as it constitutes a written record for reference in the event of any possible dispute. At the last meeting, at any rate, this certainly was not done.

If any one will take the trouble to compare the two examinations conducted by this Board—the Matriculation or Preliminary, and the Professional—they cannot fail to be struck with anomalies that present themselves at once. In the former the examination is both oral and written, in the latter oral only. In the former it is thorough and efficient, in the latter it is superficial and hasty. The former is conducted by gentlemen specially selected for their long experience in teaching and in examining pupils, the latter is conducted by examiners chosen almost at hap-hazard from a body of general practitioners without any reference to their possessing experience in teaching or in examining students. The former extends over two days, the latter (for each student) cannot exceed one hour and forty-five minutes. But the singular thing about it is, that the former —the long, searching, written and oral examination, conducted by well-known specialists—is only to find out if a young man knows enough to be allowed to begin the study of medicine: whilst the latter—the hasty, superficial, oral examination conducted by random-chosen examiners—is to determine whether or no the candidate is well versed in all the important branches of practical medicine and surgery, and whether he shall receive the License to practise in this Province.

Fortunately for the Province, the great majority of those who are licensed are holders of diplomas from our Universities, all of which are, in greater or less degree, endeavouring to raise the standard of medical education by the honesty and severity of their examinations. Now, we do not consider that the examination for the License should be of as high a grade as that for the M.D. from an University, but we do think that some advance should certainly be made in the character and procedure of the license examination as now enforced in this Province. It matters not how few the candidates are, so long as the Board retains the power of examining for a License, it should certainly not fail to make that examination at least as imposing and effective as that which it insists upon as preliminary to the commencement of study. Why should this matter not be discussed

by the Board? If they could see their way to having an *annual* meeting *only* (as we have already advocated), we believe it would be a step in the right direction. Let examiners be chosen from the members of our teaching bodies in the Province (not necessarily members of the Board), and let them be selected as having special experience in particular branches; let them meet the candidates two days before the meeting; let there be a fair written as well as oral examination; let them hand in a written report of the results; and we venture to say that the License for this Province will soon gain the respect of the entire medical community. As it is now, we know that such is not the case.

THE HARVARD CENTENNIAL.

Wednesday, the 17th of October, was a red-letter day in the history of Harvard Medical Faculty. Not only was it the celebration of its entrance upon the second century of its existence, but, by the liberality of the citizens of Boston, it was enabled formally to take possession of a building worthy in every respect of the purposes to which it has been dedicated. The exercises of the day began in the hall of the School of Technology, when Dr. Oliver Wendell Holmes, the Emeritus Professor of Anatomy, delivered one of his most characteristic addresses, dealing chiefly with the past history of the school. To the many strangers present, this was the event of the day; it was, indeed, a rich treat. It is sad to think that "haggish age" is fast creeping on the genial Professor, but though showing his years more than when we last saw him, he is still vigorous and active, and looks as if he meant to keep the great Autocrat at bay for some time to come. After the address, a portrait of Dr. Holmes was presented to the Faculty and also a bust of Dr. Bigelow, the Emeritus Professor of Surgery. The dedicatory services were held in the new building, and consisted of an address on behalf of the donors by Col. Lee, and a suitable reply by Dr. Williams. Luncheon was then served after which the visitors inspected the class-rooms and laboratories. The building is situated on Boylston street, in the best part of Boston, close to the Art Museum and other large public buildings, with which it bears comparison very favorably. It is a handsome brick structure, faced with stone, four stories high, and 120 feet front. The internal arrangements are in the most modern style and surpass anything of the kind on the continent. The Chemical, Anatomical, and Physiological Laboratories take up a large section of the building and are splendidly adapted for work. It is a very proper

thing, indeed, that Harvard School of Medicine should have such excéptional accommodation for her students and such facilities for teaching. The Faculty have led the race in reforming the lax and imperfect system of medical education which prevails in the States, and have set an example which has been followed closely by some schools, while many others have been not a little benefited. The change from the old two course system in 1871 was a very serious one ; many thought it would be fatal, but the lengthening of the course to three years, and the session to nine months, with entrance and sessional examinations, while reducing the number of the students has proved a great success. The increase of the fees has much more than compensated in income for the falling off in numbers while the quality of the students has greatly improved. In 1870-71 only 23 per cent. of them held academic degrees; last session over 50 per cent. were graduates in arts. The extra-fourth session, at present optional, is taken by an increasing number and will soon be made compulsory. It was gratifying to find the Dominion well-represented on the occasion. From Montreal were Drs. R. P. Howard, F. W. Campbell and Osler; from Toronto, Dr. Aikens, the President of Toronto School of Medicine ; from Hamilton, Dr. Mullin, President of the Canada Medical Association, and from Fredericton, N. B., Dr. Atherton. To anyone interested in higher medical education, we would recommend a trip to Harvard.

THE HALIFAX ABORTION CASE.—So far as we can learn, the facts of this lamentable occurence were as follows: a widow named O'Connor, in comfortable circumstances, became pregnant and consulted Dr. Lawson, with reference to the procuring of abortion. According to the deposition, the Doctor told her that instruments would have to be used and he would charge her $50. The operation was performed and two or three days after the woman had a miscarriage, followed by puerperal septicæmia and death. The *post-mortem* did not reveal any signs of instrumental violence. A coroner's inquest was held and the following verdict returned, " That Bridget O'Connor came to her death by abortion practiced by Dr. Archibald Lawson with criminal intent." On hearing of the woman's death and the nature of her dying deposition Dr. Lawson left the city. Dr. Lawson was one of the most prominent members of the profession in Halifax, and lecturer on the Principles and Practice of Medicine in the School of Medicine.

THE GENERAL HOSPITAL.—At the quarterly meeting of the Montreal General Hospital, held on the 14th instant, it was announced that this institution had received from Geo. Stephen, Esq., the munificent donation of $50,000. The donor stipulates that a wing for surgical cases shall be built in memory of the late Dr. G. W. Campbell, and that wards therein shall always be at the disposal of the Professor of Clinical Surgery in McGill University.

—One of our Canadian cities (not at all the largest) boasts an unusual number of advertising specialists. Their cards, as presented in the daily papers, present the usual ingenious devices for attracting attention. One, however, whose card has been sent us by a friend, gets ahead of all his *confrères*. On the back of the ticket which announces that the diseases of infancy and childhood are his *forte*, we find the following which we copy for the benefit of those who want a tip :

To ——

Having derived GREAT BENEFIT from the Medical Treatment of Dr. —— I RECOMMEND you to secure his services.

Signed, ——

We only omit the name because we cannot afford to give free advertising.

Obituary.

DR. TRUDEL.—By the death of Dr. E. H. Trudel, Montreal has lost one of its oldest and most respected physicians. Although ailing for some years, he had, up to a short time ago, been able to attend to his duties, and his death, which took place on the 5th inst., was in a manner unexpected. Born in 1820 at Ste. Genevieve de Batiscan, he received his preliminary training at the Nicolet College, and began the study of medicine under Dr. Kimber of Three Rivers. Proceeding to McGill College in 1841, he graduated in 1844, with six others, in the same class with the late Dr. Scott. Only two of his classmates remain—Drs. Godfrey and Proulx of this city. He began practice in Montreal, and early joined L'École de Medecine, and became Professor of Midwifery. In 1872 he was elected President of the School, and continued to take an active part in its management up to the present session. For years he was on the staff of the Hotel Dieu, and gave clinical instruction to many generations of students. A careful practitioner, a courteous colleague and a good citizen, Dr. Trudel has left behind him a faithful record and a memory which will long be cherished in the community.

Dr. Marion Sims.—This eminent and well-known surgeon and gynæcologist died suddenly of heart disease in New York on the 13th inst.

Wm. McGill, M.D., of Oshawa, died on the 9th inst. He was a graduate of McGill College in 1848, enjoyed a very extensive practice, and also took great interest in politics. He was for some time the local representative for Ontario, and was one of the early members of the Ontario Medical Council.

—We regret to hear of the death of Dr. Weiss, of Vienna, a Privat-Docent of the University, and well known to many American and Canadian students as an excellent teacher in General Medicine and Nervous Diseases.

—Surgeon General Crane, U. S. Army, died on Wednesday, Oct. 10th, of hemorrhage of the throat, after serving a little over a year in his new position. He entered the army in 1848. His successor has not yet been appointed. Efforts are being made to induce the Government to appoint Dr. Billings, who is undoubtedly the man for the position.

Personal.

C. M. Gordon, M.D. (McGill, '81), is practising at Aylwin, Que.

We regret to hear that Dr. F. W. Campbell was thrown from his carriage on the 10th and badly shaken.

J. J. E. Maher, M.D, (McGill, '83), has been appointed one of the District Dispensary Physicians in New York.

Dr. Ogilvie, of Kingston, Jamaica, President of the Local Branch of the British Medical Association, spent a couple of weeks in town last month.

We were pleased to have a visit last month from Hamilton Allen, M.D. (McGill, '72), of Ocionto, Wis. He is one of a large number of prosperous Canadian doctors in the Western States.

John Brodie, M.D. (McGill, '77), of Honolulu, has returned for a short visit to his friends. He gives an excellent report of the Island, where he has prospered during the past three years, as did his predecessors and friends, Drs. Vineberg and Miner.

J. B. Lawford, M.D. (McGill, '78), M.R.C.S., Eng., has been appointed House Surgeon at the Royal London Ophthalmic

Hospital, Moorfields. Dr. Lawford has been acting as Assistant to Mr. Nettleship at St. Thomas', and has been making steady progress in his professional career in London. He is the third Canadian within ten years who has held this important position. Dr. Buller, of Montreal, and Dr. Burnham, of Toronto, were predecessors.

Medical Items.

—A medical weekly, called the *Clinical and Pathological Journal*, has been started in Edinburgh. It was quite time.

—Henry J. Rogers, one of Souvielle's peripatetics, has been in the clutches of the law in St. John, N.B. The new Medical Act of that Province seems a good one.

—Our English exchanges contain a full account of the removal of Harvey's remains from the vault at Hempstead to the chapel, where a special marble sarcophagus had been prepared.

—The Medico-Chirurgical Society of Montreal proposes to undertake the collective investigation of facts relating to typhoid fever. The necessary cards will be issued in a week or so.

—A cable to the *New York Herald* from Rio states that a physician of that city has cultivated the microbe of yellow fever and is successfully vaccinating persons, who then get the disease in a mild form.

—There are 68 new entries in the Medical Faculty, McGill College. From Ontario, 40; Quebec, 17; New Brunswick, 6; United States, 2; Nova Scotia, 1; West Indies, 1; Manitoba, 1. There are over 200 names on the register.

—The Public Health Convention of the United States met in Detroit on the 13th. Several Canadian health officers were present. Dr. Oldright, President of the Ontario Board of Health, read a paper on "Overhead Ventilation of Drains and Sewers."

—Dr. Henderson, of Calgary, N. W. T., writes that he was then, Oct. 11th, attending Dr. Paul Cameron (McGill, '82), for a severe attack of Typhoid. Dr. C. had been practising at Medicine Hat. His brother, Dr. J. D. Cameron, of Iron Mountain, Mich., had come to visit him.

—The Koch cholera mission which has been at work in Egypt, has obtained permission to proceed to India to continue the investigation of the disease. It appears doubtful if the bacillus which has been found in the intestine is the *right* one, and further search is needful.

—The *Canada Lancet* states that Dr. Joseph Workman has been elected an honorary member of the Phrenatric Society of Italy. We are glad to see that his labors are appreciated by his Italian colleagues, whose writings he has so often introduced to us by excellent translations.

—The *Medical News* states that in three days thirty cases of Typhoid were admitted to the Montreal General Hospital. On enquiry we find that the admission has never reached that number in the time mentioned, and the statement has probably had its origin in a newspaper *canard*.

—Before leaving Canada, His Excellency the Governor-General and H.R.H. Princess Louise presented a very handsome despatch-box to Dr. Grant of Ottawa, who had been their physician. We understand that Dr. Grant has been notified to consider himself the medical attendant of the present incumbents of Rideau Hall, Lord and Lady Lansdowne.

McGILL MEDICAL SOCIETY.—The fortnightly meetings are largely attended this session. On October 20th, Dr. Osler read a paper "On the Duties of the Physician as Examiner in Life Insurance." Dr. Mullin, of Hamilton, Ont., the chief medical officer of the Canada Life, was present, and gave a most interesting address on the subject, full of valuable suggestions. On the 3rd ult., Mr. Wyatt G. Johnston read a paper on the "Causes of Death in Typhoid Fever," based on the records of about 50 autopsies recorded in the post-mortem books of the Montreal General Hospital.

—The Curator of the Museum, Medical Faculty McGill University, begs to acknowledge the receipt of the following specimens during the past month :—

From Dr. Harkness, Irena, Dundas Co.: "An Anencephalous Monster."

" Dr. T. L. Brown, Melbourne, P.Q.: "Periosteal Tumor of the Bones of the Pelvis."

" Dr. Mullin, Hamilton: { "Tumor of the Penis." "Tumor of Female Urethra."

" Dr. And. Henderson, Calgary, N.W.T.: "Femoral Artery accidentally divided without injury to the vein."

" Drs. McLean and Duncan, Fergus Falls, Minn.: "Maggots from External Auditory Meatus."

" Dr. Phelps, Chateauguay, N.Y.: "Cancer of Liver and Portal Lymph Glands, with Thrombosis of Portal Vein."

" From Mr. Bancroft, Veterinary Student: "Cyst on Mitral Valve of Cow."

CANADA

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Original Communications.

EXCISION OF PORTIONS OF THE INTESTINE.

By JAMES BELL, M.D.,
Medical Superintendent of the Montreal General Hospital.

(*Read before the Canada Medical Association, at Kingston, September*, 1883.)

The groundwork of my paper consists of the reports of 14 cases of experimental resections of the intestine in dogs. I was led to make this series of experiments by the observation during the past few years of a number of cases of intussusception, hernial and other strangulations, stricture, ulcer, and the various neoplasms which affect the intestinal canal, which were either subjected to equally severe, but less satisfactory, treatment, or abandoned to die as beyond the reach of surgical aid. When I say "equally severe, but less satisfactory treatment," I refer, of course, to the orthodox treatment of intussusception by inflation or even by abdominal section, and endeavoring to replace the inverted bowel; and the production of an artificial anus in hernia when the bowel had sloughed. Emboldened by the recent successes in the various branches of abdominal surgery, I reasoned that, under ordinary circumstances, almost any portion of the intestinal tract—certainly any portion of the small intestine—should be removable with the greatest ease, and if the ends could be kept in close apposition for a sufficient length of time, union should occur. I therefore proceeded to operate upon a number of dogs—although I was warned by veterinary surgeons that the dog was considered by them to be specially susceptible to peritonitis—and I consider the results most satisfactory. The follow-

ing are brief notes of the cases. I have divided them into two series of seven cases each—the difference being that in the first series catgut sutures only were used to unite the ends of the bowel, and in the second series silk sutures only were used. The operations were all done under carbolic spray:—

First Series.

CASE I.—A young mongrel terrier bitch, dirty, ill-nourished, and suffering from distemper, was operated on on the 21th of March last. An incision about three inches long was made in the median line of the abdomen. The omentum was drawn up out of the way with the finger, and a coil of the small intestine withdrawn through the wound. The several branches of the mesenteric artery leading to this portion of the bowel were ligatured by passing catgut ligatures around each with an aneurism needle. The portion of gut thus isolated, 3½ inches long, was then cut off with the scissors, an assistant holding the ends beyond, between the finger and thumb of each hand, to prevent the escape of contents. I then tried to pare away the peritoneal surface of the upper portion of the bowel, intending to push it into the lower portion after having pared away the mucous surface of it to correspond, but I found this quite impossible, as the end of the bowel contracted slightly as soon as it was cut, and the mucous membrane became everted to the extent of nearly a quarter of an inch. I then united the ends by a continuous "over and over" suture of fine catgut, cleansed the bowel thoroughly, and returned it to the abdominal cavity. I closed the abdominal wound with three silver and several catgut sutures, and covered the wound with iodoform, packing it well into the spaces between the sutures. This and all the subsequent operations were done under ether, and as the details of the operation are essentially the same in all, except in the suturing of the ends of the bowel, it will be unnecessary to repeat them. This dog was given a hypodermic injection of ten minims of Liq. Opii Sed., and this was the only medicinal treatment given. None of the others had any medicinal treatment whatever. It spent the day quietly, and took milk greedily in the evening. Its pulse was rapid, and its temperature a little high throughout. The tem-

perature was carefully taken in all the first series of cases, and shows very little elevation—the normal temperature of the dog being about 102°F., and easily disturbed. A liquid stool occurred at the end of 48 hours, and the further progress of the case was uninterrupted. The "distemper" (as shown chiefly by purulent discharge from the nose) continued, and the animal grew thinner and weaker, and died on the 11th of April, 18 days after operation. At the autopsy, 90 hours after death, the abdominal wound was found to be perfectly united and all the organs healthy. There were a few adhesions of omentum and of one coil of small intestine at the site of operation. The union of the bowel was perfect, but had produced considerable narrowing. This I attribute to the puckering produced by the continuous suture. The specimen is labelled "1."* The death in this case, I believe, was due to the "distemper," as there was no other evident cause.

CASE II.—This dog was a healthy, well-nourished young mongrel, with some resemblance to the otter-hound species. When brought up for operation on the 28th of March, I found him gorged with meat. My rule in all the cases was to keep the dog on low diet for about two days before operation, and on a moderate milk diet afterwards. This dog had been fed about an hour before the operation by an over-zealous and too humane servant. I proceeded with the operation, however, and removed three inches of the small intestine in the same manner as in the last case. The ends of the gut were brought together by a double row of catgut sutures. The first row consisted of as many interrupted sutures as could conveniently be inserted, and the second row of a continuous "over-and-over" suture, catching the spaces between the former. The bowel was returned, and the abdomen closed and dressed as in the other case. Copious vomiting of undigested food occurred half an hour after the operation, and a solid stool was passed about 60 hours afterwards. The abdominal sutures were removed on the ninth day, and the dog continued in perfect health. On the 29th of June I ligated his right carotid artery with catgut. He recovered, without a bad symptom; and on the 26th of July, just 4 months

* Portions of bowel, showing the results of operation in each case, were exhibited in connection with the paper.

(less three days) after resection of the bowel, I killed him by pithing. The body was well nourished—in fact, quite fat—and there were no adhesions in the peritoneal cavity. The organs were all healthy and the bowel perfectly united.

CASE III.—A healthy, well-nourished mongrel bitch; 12½ inches of intestine were removed in the usual way on the 30th of March, and the ends of the bowel united as in Case II. A similar stool was passed on the third day. There was slight elevation of temperature for two or three days, but otherwise the dog was perfectly well after the first 24 hours. She took milk greedily, was playful and active, and never had a bad symptom throughout. On the 20th of April, I gave her ether and cut one of her costal cartilages subcutaneously to observe the process of repair in it. On the 29th of May, two months after the first operation, I gave her ether and bled her to death by cutting the femoral artery across. At the autopsy, the body was found to be well-nourished, all the organs healthy, no adhesions in the peritoneal cavity, and the union of the bowel perfect. There was no union of the costal cartilage.

CASE IV.—A bright, active, young fox-terrier; six inches of small intestine were removed on the 3rd of April. The ends of the bowel were united with twelve interrupted and a continuous catgut suture. The abdominal sutures were removed on the fifth day, when he was apparently perfectly well in every respect. He continued well, and grew fat, until the 22nd, when he had a chill, and became feverish. Symptoms of "distemper" came on, and he grew gradually weaker from day to day, and died on the 18th of May, 45 days after the operation. There was slight prolapse of the omentum after removing the abdominal sutures, but it required no treatment. At the autopsy, all the organs were found to be healthy, and the union of the bowel complete and without adhesions.

It will be observed that in this specimen there is at one place a deficiency, or rather an absence, of mucous membrane. This is due to the fact that in this case I tried to include in my sutures only the peritoneal and muscular coats when uniting the ends of the gut. I found it so difficult, however, that after doing a small

portion of the circumference in this way, I desisted, and did as in all the other cases, catching the whole thickness of the bowel, mucous membrane and all, in my sutures. The deficiency in the mucous membrane corresponds (in extent at least) to the portion of bowel sutured in this way.

Case V.—A young, active, and well-nourished mongrel hound was operated on on the 3rd of April. Nine inches of bowel were removed, and the ends united by 52 interrupted catgut sutures. He did well, and on the 7th of April, four days after operation, I removed the abdominal sutures. A liquid stool occurred during the operation. In this and the last case I was unable to determine when the first stools were passed after operation, as I had a number of dogs on hand, and was obliged to keep these two in a room with two others. On the next day I found the abdominal wound open and a large omental protrusion. On the following day I gave him ether, re-opened the wound completely, and returned the omental hernia. He never was right after this operation, and sank gradually, dying on the 14th, eleven days after the resection, and four days after the operation for the return of the omentum. At the autopsy, there was gaping of the ends of the bowel, escape of contents, and general peritonitis. The bowel was partially united. The abdominal sutures were removed too early (on the fourth day), and I attribute the death of this animal to the violence employed in giving ether a second time and returning the omentum. This, I think, probably partially separated the recently united bowel, allowing escape of fæcal matter into the peritoneal cavity.

Case VI.—A toy Scotch terrier pup, weighing 3¼ lbs., was operated on on the 5th of April. Five inches of bowel were removed, and the ends united by interrupted catgut sutures. Very fine gut was used, as the bowel was very small. The dog did quite well for 48 hours, but was found dead a few hours later. At the autopsy, the ends of the bowel were found lying about three-quarters of an inch apart, the catgut having given way everywhere, and the intestinal contents in the peritoneal

cavity, which was intensely engorged throughout. The result of this case determined me to use silk sutures, though I did one more case with catgut.

CASE VII.—A mongrel black and tan, aged. Ten inches of gut were removed on the 8th of April, and the ends united by a double continuous suture. The first round was the ordinary post-mortem-room suture—every stitch inserted from within outwards. I did not like the appearance of this when done, and I put in a second round of "over-and-over" suture of catgut also. The bowels moved on the second day, and the dog made an uninterrupted recovery. On the 29th, I cut one of his costal cartilages subcutaneously, which produced no bad symptoms. On the 3rd of June, 56 days after the operation, I killed him by blowing air into the jugular vein. At the autopsy, the organs were all healthy. There was no trace of peritonitis, and the bowel was perfectly united.

Second Series.

CASE I.—An aged black terrier. Eight inches of bowel were removed on the 20th of April, and the ends sutured by twenty interrupted sutures of fine carbolized spun silk. The bowels were moved the same night, a solid stool passing, and the dog made an uninterrupted recovery. On the 10th of June, 51 days after operation, I killed him with prussic acid. All the organs were healthy, and the body well-nourished and fat. There was slight adhesion of two coils of intestine at the point of resection, and the bowel was united perfectly.

CASE II.—A young mongrel terrier. Five inches of bowel were removed, and the ends united by fine silk sutures. The dog never rallied, and died 68 hours after the operation. At the autopsy, all the organs were found to be healthy. There was general peritonitis, the peritoneal cavity containing about 3 ounces of grumous fæcal matter. The ends of the bowel were found to be in perfect apposition and the silk sutures holding firmly, but at a point near the mesenteric attachment a segment of the gut had been overlooked and no suture applied, hence the escape of its contents and the bad symptoms from the

first. The sutures have been lost through slitting up the bowel—in fact, the deficiency was not noticed until the bowel had been opened up.

CASE III.—A young mongrel terrier. Seven inches of bowel were removed, and the ends united by 28 interrupted sutures, 15 of silk and 13 of catgut (my supply of silk having given out). Just after the abdominal wound had been closed, a violent fit of vomiting came on, and the abdomen was filled with air, which could be heard escaping through the wound in the bowel. The dog did badly from the first, and died at the end of the fourth day—about 101 hours after the operation—from peritonitis. At the autopsy, all the organs were found to be healthy, and the sutures in position, though slackened, and the ends of the bowel somewhat separated. This specimen was not preserved.

CASE IV.—A toy terrier bitch, weighing about 3 lbs., decrepit with old age, and blind from double senile cataract. Ten inches of bowel were removed and the ends united by 21 interrupted sutures on the 3rd of June. The bowels were moved on the second day, and there never was a bad symptom. She died on the 4th of August, 62 days after operation. She showed no signs of disease, and died, I believe, of senility. The bowel was found to be perfectly united, and there were no traces of peritonitis. This specimen was, unfortunately, neglected for a couple of days, and was destroyed by the great heat then prevailing (August 4th.)

CASE V.—A small and young smooth terrier. Ten inches of bowel, including the cæcum, were removed in the ordinary way and the ends united by 20 interrupted sutures of fine spun silk on the 24th of June. On the 27th, a solid stool was passed. There never was a bad symptom throughout. The abdominal sutures were removed on the 14th day, and the dog was killed by pithing on the 25th of July, 32 days after operation. At the autopsy, the organs were all found to be healthy, and the body well-nourished. There were a few adhesions around the wound in the bowel, but the union was perfect. This specimen shows the attachment of the small to the large gut.

CASE VI.—A young mongrel black-and-tan bitch. Four and a half inches of small intestine were removed and the ends united by 22 interrupted and a continuous suture of fine spun silk on the 1st of July. On the 3rd, a semi-solid stool was passed; and on the 8th, the abdominal sutures were removed. The dog was lively and well throughout. On the 25th, twenty-four days after operation, I killed him by pithing. All the organs were healthy, and the body well-nourished. There were some adhesions between the bowel and the abdominal wall, but the union was perfect. I may note here that although only twenty-eight days had elapsed from the operation, not a trace of the silk sutures could be discovered at the autopsy, and you will observe that the union of the bowel is as complete as in those which survived the operation for months.

CASE VII.—An aged mongrel terrier; 13 inches of duodenum, close to the stomach, were removed on the 8th of July, and the ends united by interrupted sutures of fine spun silk. He did not seem to suffer any inconvenience from the operation, and was well and lively, and took his milk greedily. At the end of the third day I left the city for a few days, and on my return, was disgusted to find that he had escaped. I never saw nor heard of him afterwards, but I have reason to believe that a tender-hearted domestic set him at liberty on the day after I left, not knowing that he had been operated upon.

Now, to summarize the results of these operations,—of the 14 dogs operated upon, 4 died from the effects of operation, but all from preventable causes. The first from the giving way of the catgut sutures too early; the second from meddlesome surgery; the third from careless surgery, and the fourth from an accident which could not have been foreseen. Of the remaining 10, one died of senility 62 days after operation, and two died of "distemper"—one on the 18th and one on the 45th day after operation. Six made perfect and complete recoveries, and did not suffer in nutrition or digestion, nor in any other way, and were killed at periods varying from one to three months after operation. Of the fourteenth we have no record. In the first case only, was there any constriction of the bowel, and in no case

was there the sign of any considerable peritonitis. In fact, in three cases there was absolutely not an adhesion in the peritoneal cavity, and the autopsy might have been made in good faith without discovering that the bowels had ever been interfered with.

I have never seen the operation done on the human subject, but I would submit here the following reports of three cases which have come under own observation during the past year and a half, and which were, I think, suitable cases for this operation. I could mention other cases as well, but prefer to give only these three as examples of some of the different conditions in which I believe the operation to be indicated. Moreover, in the first two cases, I am able to give the report of the post-mortem examination in corroboration of the diagnosis made at the bedside :—

Case I.—M. W. was admitted to hospital on the 25th April, 1882, with a small and freely movable tumor below and to the right of the umbilicus. She complained of "constipation," and stated that the first difficulty experienced was eight weeks before admission, and after taking a dose of castor oil. This failed to move her bowels satisfactorily, and caused severe pain and troublesome vomiting for two days. She then felt a tumor for the first time. She had suffered ever since from digestive disturbances of various kinds, and had attacks similar to the one described whenever a purgative was taken. After several days' observation, during which there was no pain nor elevation of temperature, nor other sign of constitutional disturbance, a diagnosis of fæcal accumulation was made, and the patient ordered a black draught. This was followed by the most serious and alarming symptoms—pain, vomiting, distension of the bowel above the tumor, and a condition bordering on collapse. There was also complete inability to evacuate the bowels. This condition lasted two or three days, until she had had several small liquid stools, and then the symptoms passed off. Very little change occurred for two or three weeks, when inflammation took place around the tumor, and a circumscribed abscess formed and pointed in the abdominal wall. A minute exploratory opening

was made into this abscess, and some pus and fæcal matter escaped. A week later, June 9th, she died of exhaustion. At the autopsy was found a circular ulcer about three-quarters of an inch in width, and extending around the greater part of the circumference of the inner surface of the bowel, and almost completely occluding it. The portion of bowel involved was the hepatic flexure of the colon, and a small perforation had occurred just above the stricture, and produced the localized inflammation which ended in abscess.

CASE II.—The following case was reported at the Medico-Chirurgical Society of Montreal by Dr. F. W. Campbell at our last April meeting. The report is copied from the CANADA MEDICAL AND SURGICAL JOURNAL:

A. B., a stout woman, aged 64, had had an irreducible umbilical hernia for 15 years. She had a painful attack in the hernia four years ago, which subsided in a few days. She was seen by Dr. Campbell, on the 9th of April last, for great pain in the sac. The pad had slipped off, and without waiting to replace it, she jumped out of bed and was immediately seized with great pain. The hernia had been increasing in size lately, and the pad had become too small. The hernia was easlly reduced to its ordinary size, and Liq. Opii Sed. given. An enema brought away a quantity of scybalous matter. In the afternoon vomiting set in. On the 10th and 11th she was easier, but vomiting was excessive. An injection brought away a large fæcal stool. She had a restless night on the 12th, and more pain, and was seen by Drs. Howard and Fenwick, with Dr. Campbell, with a view to operating, if considered advisable. It was decided not to operate, and during the 13th and 14th she improved a little, but died suddenly on the morning of the 15th. The autopsy showed a thin-walled umbilical sac, not inflamed. In it were two coils of intestine—one, about 13 inches in length, was dark-colored, deeply congested, and inflamed; the other, 9 or 10 inches long, was natural-looking, though a little swollen. There was no adhesion of the bowel to the sac. The inflamed portion of bowel presented two flat bands of slightly thickened peritoneal tissue, where it had probably been for years in contact with the

ring. The inflammation had extended along the adjacent coils in the abdomen for a few inches. When slit across, the mucosa was intensely inflamed, of a deep, livid red color, and covered with closely adherent flakes of croupous exudation. The heart was fatty. There were no other changes of note.

CASE III.—In October, 1882, a strong, healthy, and well-developed French-Canadian, aged 22, came to hospital to see what could be done for an inguinal hernia, which had become strangulated, and had undergone spontaneous cure by sloughing through the skin of the groin. He had been working in a lumber shanty in Michigan in the previous winter, and while lifting produced a right inguinal hernia. Symptoms of strangulation supervened immediately, and as he was quite out of the reach of medical aid, he laid up in his shanty. An "abscess" formed and burst of itself, and he has since discharged all his fæces through this opening in the groin. He consulted a doctor as soon as he was able, but there was then nothing to be done except to devise a truss to retain the bowel and collect the fæces. When I saw him I had considerable difficulty in getting him to remove the pad, for he assured me that I had no idea of the mess it would make. And I certainly had not. When he removed the pad, the everted bowel rolled out in spite of him for, at least, many inches, and poured out a quantity of thin, semi-feculant matter, and he was obliged to lie down upon his back to get it returned, and even then he had difficulty. I advised him then that nothing could be done for him. I would now, I believe, with the light of subsequent experience, lay the matter fully before him, and advise that the opened portion of bowel (which was, I have no doubt, small intestine) be excised, the ends united and returned to the abdomen, and the artificial anus in the groin closed. Now, although the operation can scarcely be said to be a recognized one, especially in this country, the journals of late years record numerous cases, chiefly in Germany, but also in England and in America, in which it has been performed with very great success. For example, Prof. Czerny, in the *Berliner Klinische Wochenschrift* (45, 1880), reports three cases of intestinal resection,—in two cases, the removal

as the result of his experience, that only one case in 60 was suitable for operation. Ovariotomy, Oophorectomy, and the various operations upon the uterus and its appendages, are always attended with considerable injury to the peritoneum, and much danger of escape into the cavity of irritating fluids and of blood, and yet they are surprisingly successful, and, now-a-days, always undertaken without hesitation. Abdominal section is now frequently performed as a *dernier resort* in cases of obstruction of the bowel from invagination, although, I believe, comparatively few surgeons have yet gone the length of excising the obstructed portion when it has been found impossible to reduce it, or where sloughing has occurred. Even when the invagination has been successfully reduced, difficulty is often experienced in returning the distended intestines to the abdominal cavity, and the common practice seems to be to puncture the bowel in several places to allow of the escape of gas. I would suggest that it would probably be safer to make a free cut across the front of the bowel, outside the abdomen, allow the gas to escape, and stitch it up carefully and return it. I believe it would be safer for two reasons. First, because such a wound could be more perfectly closed than several punctures; and, secondly, the gas would all escape at once and outside of the abdomen, whereas, when punctured, it would only escape gradually, and probably continue to escape after the gut had been returned to the abdomen. In hernia, where the bowel has sloughed, I believe resection would not only give an incomparably better result if successful, but would be a safer operation. In conclusion, therefore, I would submit the following propositions:—

1. That the intestinal canal, from the pylorus to the rectum, is subject to many local diseases which are not amenable to medicinal treatment. As examples, I might mention ulcer, stricture, impaction of contents, obliteration or sloughing from strangulation or inflammatory action, and the different neoplasms which affect the intestinal walls.

2. That the diagnosis and the approximate location of such lesions is usually easy and satisfactory.

3. That resection of any portion of this tract, especially of

the small intestine, is a simple and easy operation, and from what little experience we already have of it in the human subject, a safe and satisfactory one.

4. That in the operation itself, catgut is not to be relied upon as a suture; that silk sutures are readily absorbed in the peritoneal cavity, or, at least, that they disappear rapidly without producing any irritation; that several of the sutures, if not all, should be interrupted, to prevent puckering and narrowing at the point of union; and that perfect union occurs when the whole thickness of the bowel is included in the sutures. It is therefore unnecessary and unadvisable to pare away the everted mucous membrane.

5. That removal of intestine, even in considerable portions, does not seem to affect digestion or nutrition.

CASES IN PRACTICE.

By Drs. McLEAN and DUNCAN, Fergus Falls, Minn.

Case I.—*Maggots in the Ear.*—G. S., aged 24, Norwegian, came to our office on Sunday morning, Aug. 19th, complaining of very severe pain in left ear. Patient's appearance was that of a man suffering intense pain, face distorted and anxious looking, and he was groaning with agony. Had measles and scarlet fever when six years of age. Thinks that his left ear troubled him a little after measles, but he is not very sure. Says there has never been any discharge from the ear. Hearing has always been good. Has always been quite healthy till last Friday morning, Aug. 17th, when present trouble began. Says that when he awoke on Friday morning he felt a little pain in left ear; pain was of an aching character, and increased in severity very rapidly; says he could not sleep that night on account of the pain. On Saturday, Aug. 18th, pain was so severe that he went to a doctor, who gave him some Tr. Opii, telling him to put in a few drops several times a day. On Saturday night pain was much worse; says it was almost unbearable. The drops had no effect whatever; did not sleep that night on account of the pain, and says the pain has increased in severity ever since.

On examination, left ear is found to be alive with maggots.

The ear is almost full of them, so full that they can be seen without the aid of a speculum or mirror. We at once proceeded to remove them by syringing with warm water, but as they did not come away readily by this method, we had recourse to ear forceps, with which we picked out 21 living maggots, giving instantaneous relief. The membrana tympani was found to be entirely absent, and the whole middle ear and external auditory canal was denuded of mucous membrane and skin. Blood was oozing from the whole surface. The canal was now well syringed out with warm water, and dried with absorbent cotton, and when exposed to the air for a few minutes the bleeding ceased. Finely powdered iodoform was blown in, and a small piece of cotton wool placed in the orifice to keep the part clean. The maggots were each seven lines in length and about one line and a half in thickness, and were very active in their movements. They adhered so closely to the canal wall that they could not be removed by syringing, so that the forceps had to be used.

Aug. 20th.—Patient entered our office this morning with a beaming countenance. Slept well all night; has had no pain since the removal of the maggots. To-day there is a profuse muco-purulent discharge. Ear syringed out and a solution of Arg. Nit. gr. xl, ad ℥i, applied to the excoriated surface; some finely-powdered iodoform was also blown in, and to have a tonic of Ferri et Quin. Citras gr. v t.i.d.

Aug. 21st.—Patient returned this morning looking and feeling much better; discharge considerably less; denuded surface assuming a healthier appearance. Above treatment continued.

Aug. 26th.—The discharge from the ear has decreased every day, and to-day the whole denuded surface is entirely healed. Has had no pain since the maggots were removed, and says he hears quite as well as he ever did.

The probabilities are that these maggots did not crawl into the man's ear, but that they were developed there; and if they were developed there, a fly must have had access to his ear and deposited its larvæ there. But the question is, what attracted the fly into his ear? And supposing that the man's ear was perfectly free from discharge, would these eggs develop into

maggots? Our patient gives an indefinite history of having a sore ear following measles, but he states positively that there has never been any discharge since then. It is a recognized fact that flies are attracted to the ear by an offensive otorrhœa, and that their larvæ, deposited in this discharge, will develop into maggots. We think that the membrana tympani has been absent since he had the measles, because he says that he hears quite as well now as he ever did, and his hearing is by no means perfect; and that there was some discharge from the ear at the time these larvæ were deposited.

CASE II.—*Pelvic Hæmatocele.*—Mrs. W., aged 28; has been married twelve years; has given birth to two premature children, both delivered at seven months. In both cases labor was severe and protracted, and forceps were used each time. Both children died a few hours after birth. The first labor was five years ago, the second one ten months after. Never pregnant since. Patient began to menstruate at the age of nine, and was always regular till one year ago, when she menstruated every two weeks, and sometimes oftener; this has continued till the present time. Says each period lasted five days, the flow being profuse. Health otherwise has been good. Patient is of slight build, but is healthy-looking; is not anæmic, but has good color, though not plethoric. Began to menstruate on the morning of August 9th, and on the following day she was out in the rain and got her feet wet; she had a slight chill that afternoon, lasting a few minutes. About four o'clock a messenger came in great haste. On entering the house, found the patient suffering intensely; countenance anxious; face very pale; brow covered with beads of sweat; extremities cold; respiration sighing; pulse rapid (116), and extremely small. Feels very faint, and complains of nausea. Says the pain came on very suddenly, and the menses stopped as soon as pain began.

On examination, left iliac region is found to be a little full, and exquisitely tender. Thinks the pain is slightly relieved by drawing up the legs. Ice was at once applied to the painful spot; heat to the extremities; and gave Acid. Gallic. gr. xx and gr. v, to be repeated every four hours; also gave Morph. Sulph.

gr. ⅓ hypodermically. One hour after treatment commenced, the pulse was improved (90 per minute), and the feeling of faintness disappeared, but pain no less. Was given Morph. Sulph. gr. ¼ hypodermically. At 7 o'clock, three hours after first visit, patient felt better; pain less, but still severe; pulse better; temperature normal; color improved; no nausea; no faintness. Ice and gallic acid to be continued all night.

Aug. 11*th.*—Patient slept very little all night as the pain was severe; pulse 76, rather feeble; temperature normal; respirations 24, very shallow, as a deep inspiration increases the pain in the groin. This morning a tumor can be felt in the left iliac region, nearly as large as a fœtal head, which is extremely tender. Vaginal examination shows the fundus of the uterus pushed slightly to the right, but not adherent, it being freely movable. Great tenderness about the left ovary and broad ligament. She was catheterized every eight hours, the ice being continued, and Pulv. Opii gr. i given every four hours. For four days the patient appeared to be doing well. There was always some pain present, and the tumor, which kept about the same size, was extremely tender, but there was no severe pain till the afternoon of the 15th, when the patient, contrary to orders, raised herself up in bed. She was at once seized with an attack more severe than the first one, all the symptoms being exaggerated. The same treatment was followed. Acid Gallic gr. xx was given at once. Morphia gr. ⅓ given hypodermically; repeated in an hour. The severe pain continued until the patient was completely under the influence of morphia, which was not until gr. 1½ had been given. On examination, the tumor in the left iliac region appeared larger than when previously examined, and was still extremely tender.

Aug. 16*th.*—Patient's condition much better, but still has constant pain in left iliac region, and tumor very tender. Ice applied constantly. Pil. Opii gr. i and Acid Gallic gr. v every four hours, and an occasional hypodermic of morphia. Was kept perfectly at rest on her back, and given light diet.

Aug. 18*th.*—Patient feels comfortable, but has a little constant pain. Tumor still felt, and the tenderness as before.

Bowels moved to-day by a large oil enema, the first time for six days. After this the bowels moved naturally, and patient improved steadily. The pain disappeared, and the tenderness gradually grew less. The tumor also became less evident.

One week after the last severe attack, pain was entirely gone, and the patient could pass urine naturally. She was now given quinine sulph. gr. i three times a day, and allowed a little wine. On the 26th, the tumor could not be felt even by a bimanual examination; and as there was no tenderness, the patient was allowed up a short time. She improved rapidly, and never had any elevation of temperature or chills. On Sept. 1st she began to menstruate. She was at once put to bed and kept quiet. The flow lasted four days, being quite natural in every respect, and unaccompanied by pain. Appetite and strength now rapidly improving, and all functions of the body performed normally.

OUR LONDON LETTER.

(From our Special Correspondent.)

LONDON, Nov. 21, 1883.

Through the kindness and courtesy of Mr. J. Knowsley Thornton, I have had opportunity of witnessing three operations performed by him at the well-known Samaritan Hospital. Two were cases of ovariotomy proper; the third an operation for removal of the uterine appendages in a case of fibroid tumor, which caused at times alarming hemorrhage.

It is not my intention in this letter to give the histories of these cases, as there was nothing very peculiar about them, but merely to refer to a few details which struck me as worthy of note in connection with the operation of ovariotomy as performed at the "Samaritan."

Mr. Thornton is the most thorough *Listerite* I have met in London, not even excepting Lister himself. He uses the carbolic spray of the usual strength (1 to 40), and causes it to be thrown in a heavy cloud directly on the wound. The instruments and sponges (of which latter he uses a great variety in shape and size), are treated in the ordinary antiseptic fashion. The only ligature material, however, employed by this operator is

Chinese silk, of which he uses two sizes only, the large for ligaturing the pedicle, the smaller for securing bleeding points. No wax is used in the preparation of these ligatures, but they are simply soaked for a couple of hours previous to the operation in a 1 to 20 carbolic solution, and taken directly out of this when required. Mr. Thornton thinks that wax interferes with the process of encysting or absorption of the ligature, as the case may be, and is apt to induce suppuration and abscess. This silk, besides, has the advantage of being so strong, that a ligature of comparatively small size can usually be trusted to secure the largest pedicle. No serious objection is made to catgut, beyond, perhaps, its uncertain strength, and the fact that it cannot always be relied upon to hold those large masses of omentum that sometimes require ligation.

The ovarian sac being exposed, no attempt is made to separate adhesions or ascertain their presence by the introduction of the hand, for ever so short a distance, but the trocar is at once introduced in an oblique direction, and the liquid contents allowed to run off over a rubber sheet to a receptacle on the floor. The trocar used is similar to that devised by Sir Spencer Wells, but it is covered at the distal end, and there is no tube attached. The patient is never turned on the side to facilitate the evacuation of the sac-contents, the sac, as it empties, being slowly, but forcibly, withdrawn, when, if any adhesions be present, most of them will be found at the same time to give way. The firmer adhesions are usually ligatured at once, and then divided by scissors, so that often large portions of the omentum are left adhering to the tumor. This obviates, in great measure, the troublesome hemorrhage which often follows the forcible separation of adhesions. The solid perchloride of iron is preferred as a styptic in the case of the finer bleeding points, which cannot be so readily treated by ligature.

Mr. Thornton has not had occasion to drain in his last series of two hundred operations, but, as it happened, in one of the cases which I had the privilege of seeing, drainage was deemed necessary, for the reason that the cyst had suppurated, and some of the contents, it was thought, had escaped into the peri-

toneal cavity. The drain consists of a thick glass tube, from 4 to 6 inches in length, and having a slight flange-like projection round the outer end, so as to allow of its being secured at the lower angle of the wound. When the drain is used, the dressings should be changed every twelve hours for the first three or four days, at the end of which time usually it can be removed.

As to the wound, this is closed by silk sutures applied at very short intervals, and made to traverse the tissues not further than an eighth of an inch from the edge in any part. This is said to secure a firmer and more lasting cicatrix than when fewer, but deeper, sutures are employed. The wound is covered with protective and the ordinary carbolized gauze-dressing, but the latter is seldom made longer than about ten inches square, being supported and overlapped in every part by a pad of salicylic cotton. The whole is kept in position by a flannel binder. Mr. Thornton believes that much of the obstinate vomiting which often follows the removal of large ovarian tumors is due in some measure to the loss of support which the stomach sustains, and hence he is in the habit of placing a pad over the region of that viscus for a few days, or until it becomes accustomed to the new order of things.

With regard to the after-treatment, I find that the catheter is used, in the majority of cases, for the first forty-eight hours only, as, in the hands of the most careful nurse, a troublesome cystitis has been known to follow its long-continued employment. While I think it would be absurd to lay down any hard and fast rules in connection with this point, when so much depends on the case, still I am convinced, from my own limited experience, that the catheter is often had recourse to days after it is really required. The dressing is seldom touched till the sixth day, and then is usually removed without the spray, the wound being covered with boracic lint held in position by broad strips of ordinary adhesive plaster.

The Samaritan surgeons still prefer the bichloride of methyline as an anæsthetic, although I have been led to understand that ether has never been given a fair trial by them. Keith of Edinburgh, the celebrated ovariotomist, on the other hand, has used

nothing but ether for many years. By the way, I find a strong prejudice existing in some hospitals against the latter anæsthetic, but I feel convinced that it has originated from the fact that the common commercial article has been employed, and we all know how uncertain and even dangerous that can be. Squibb's ether is almost unknown on this side the water, or I believe that anæsthetic would rapidly take the place of both chloroform and methyline, because I know many who are very much dissatisfied at any rate with the former.

The above are a few rambling notes which I took away with me from the Samaritan Hospital, and although many may deem them trivial and unworthy of notice, I doubt if any one of them is without its value. It is well known that the great success which has attended the operation of ovariotomy in the hands of certain surgeons is not attributable to any extraordinary skill which they possess as operators, but to an earnest attention to detail, so that apparently the most trifling matter often receives an amount of attention which, to the ordinary bystander, may appear unnecessary and even ridiculous. T. G. R.

QUARTERLY RETROSPECT OF SURGERY.

PREPARED BY FRANCIS J. SHEPHERD, M.D., C.M., M.R.C.S., ENG.
Surgeon to the Montreal General Hospital; Professor of Anatomy and Lecturer on Operative and Minor Surgery, McGill University.

Excision of Knee Joint.—Mr. Richard Davy, F.R.C.S., of the Westminster Hospital, London, has lately advocated (*Brit. Med. Jour.*, October 20th, 1883,) a new method of resection of the knee joint, which he calls *Tibio-femoral Impaction*. The method consists in removing the end of the femur so as to leave it wedge shape, the wedge sloping from before, downwards and forward, a mortise is then cut in the head of the tibia and into this is pushed the tenon-shaped end of the femur. The leg is placed in a splint specially designed by Mr. Davy, and pressure is kept up on the foot until "impaction results in fixity of tenure." Mr. Davy claims that the advantages of his operation are, "that osseous ankylosis is established (so to speak) before the patient leaves the operating table and many surgical

contentions are removed, such as the misplacement of bones by startings, jerks, or inefficient bandging." Mr. Davy admits that considerable shortening results from this procedure, but he does not think this an objection. Like many of Mr. Davy's operative novelties, we fear this new method of excision will not be enthusiastically adopted by the surgical world, the operation is certainly a new one and should be placed under the head of mechanical surgery. Mr. Davy has performed excision now twenty-one times, in every case without special antiseptic precautions. He has never lost a case and has only been compelled to amputate once. Dr. Fenwick, Prof. of Surgery in McGill University, has lately published a work on excision of the knee joint, in which he reports twenty-eight cases of excision with one death (this occurred before the introduction of antiseptic surgery), and two where amputation had to be afterwards performed. Dr. Fenwick's method of operation, which is original with him, is to round off the end of the femur by removing a thin slice with a Butcher's saw, and then sawing out a concavity in the head of the tibia, fits the convexity of the femur into it. By this means osseous ankylosis is secured, and also early fixity of the parts, thus he accomplishes in a much more conservative way, and without the sacrifice of the epiphysal ends of the bones, all that Mr. Davy claims for his wedge and mortise operation. Dr. Fenwick performs all his excisions with the strictest Listerian precautions. His results have been good, as I can testify, many of the cases recovering with less than one inch of shortening, and the majority with less than two inches, besides the growth of the limbs is not interfered with, as Dr. Fenwick proves by reports of cases of excision performed on children whose limbs were measured several years after the operation. The splint used after the operation is that of Dr. P. Heron Watson, of Edinburgh.

'*White Swelling*,' *Treated by Scott's Dressing*.—Dr. Perrier (Thèse de Paris, 1882,) says that this method of treatment has fallen into unmerited oblivion. M. Suchard recalled attention to Scott's dressing in 1879 and trials were made at the Children's Hospital which gave important results. M. Suchard's method

is to first cleanse the skin by rubbing it with a sponge or coarse cloth steeped in camphorated spirit; afterwards to cover the whole region with a piece of lint spread with a thick layer of the ointment, composed of equal parts of camphorated *unguentum Hydrargyri* and soap cerate. This is kept in position by straps of sticking plaster, and over these straps he places valves of flexible leather spread with soap cerate, this extends above and below the other dressing; a linen bandage is placed over all. The dressing is removed every two or three weeks. Dr. Cazin, chief physician of the Hospital at Berck-sur-Mer, has also modified the preceding apparatus. He replaces the mercurial ointment with vaseline and covers it with cotton wool, over this he applies the strapping of sticking plaster and then another layer of cotton wool is put on and this is covered with a silicated bandage, when this apparatus is applied the children are allowed to play about the hospital and beach. The dressing is renewed every fortnight. Sometimes the application causes intense erythema which is removed by washing and powdering the skin and wrapping it in a linen bandage for two or three days.—(*London Medical Record, Nov.* 15, 1883.)

On the Immediate Treatment of Fractures by plaster-of-Paris.—At the recent meeting of the British Medical Association held in Liverpool, Messrs. Christopher Heath and John Croft read papers on the above method of treating fractures. (*British Med. Jour.*, September 22nd, 1883.) Mr. Heath's paper pointed out that many other fractures besides those of the leg might be satisfactorily and easily treated by plaster-of-Paris bandages or splints, such for instance as fractured thighs in children, Pott's fracture, fractures of the humerus, clavicle, &c. Mr. Heath thinks that unless the fracture be near a joint, the joint should not be included in the plaster, and that to enclose joints unnecessarily with plaster-of-Paris, is to provide cases for the bone setter, so he never includes the knee or hip joints in any ordinary case of fractured shaft of the tibia or femur. Fractures of the forearm are the only ones which Mr. Heath thinks unsuited for this method of treatment for the obvious reason that there would be great danger of drawing the

bones together. Fractures of the olecranom he treats by flexing the arm to a right angle and allowing the patient to wear it in a sling. Mr. John Croft reported that he had treated over nine hundred cases of fractures of various bones by the immediate application of the plaster-of-paris splints with the best results. Each splint is constructed of two layers of flannel, the outer layer carries the plaster and the inner layer protects the skin. The splints are kept in place by muslin bandages. The flannel or old blanket for the splint should be cut to the shape of limb; for instance, in applying a leg splint measure circumference at knee, calf, above the ankle, from the front of the ankle just round the heel to the front again, and at the middle of the metatarsus. Then cut the flannel half an inch less in breadth than half the circumference at those points. The four pieces of flannel then make two splints; the outside pieces are soaked in plaster of the consistence of thin cream and then laid on their respective inside pieces, whilst traction is kept up and the ends of the broken bones are maintained in apposition the splints are to be applied and smoothed and then the muslin bandage put on. Traction is to be maintained during the hardening of the plaster; this takes place in about three minutes. The bandage should not be too tight and should be evenly applied. The splints should not meet by half an inch down the front or back, as the swelling subsides the splints should be tightened by means of the bandages, and at the end of ten days if the patient be convalescing the outside bandage may be gummed, and at the end of a fortnight or three weeks the patient may leave for his own home.

In the discussion which followed the reading of these papers Dr. Gay, of Boston, U.S., said that this method of treating fractures had been in use in the Boston City Hospital for some years with very satisfactory results. Gauze was used instead of flannel and the limb was first wrapped in cotton wadding. The gauze was dipped in the plaster and applied to the limb and secured with an ordinary bandage. The layer of gauze did not meet in front by about an inch and the case could be sprung open at any time, removed and re-applied.

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British Med. Jour., September 22nd, 1883.

Mr. Heath pointed out that many other fractures of the leg might be satisfactorily and easily treated by Paris bandages or splints, such for instance as fractures in children. Pott's fracture, fracture of the [illegible] Mr Heath thinks that [illegible]

[illegible] and very various are the means recommended [illegible] the separated fragments. Some think the [illegible] is altogether to blame for the separation of [illegible] so treat the fracture by methods calculated [illegible] upper fragment; others say that separation is [illegible] blood and serum, and advocate the withdrawal [illegible] others, as Prof. Hamilton of New York, [illegible] not to be desired, as it can rarely be com- [illegible] weak bone, so they endeavor to get as [illegible] as possible by the application of bandages

[illegible], Nov. 3, 1883), in his address, relates [illegible] and old fractures of the patella treated by [illegible] together of the fragments. In all the cases, [illegible] free movement of the joint was the result. [illegible] advocates this method of treatment, as the one [illegible] to give the patient a useful limb. Six of these [illegible] shown to the Society, and in all the patella was per- [illegible] natural in appearance and moved freely. Prof. Lister, [illegible] as 1873, treated successfully ununited fracture of the [illegible] process of the ulna by wiring the fragments together, [illegible] in 1877 first treated fracture of the patella in the same [illegible] He first exposes the separated fragments by a longitudinal [illegible] two inches long, then with a common brad-awl perforates [illegible] fragment obliquely, so as to bring out the holes upon the [illegible] surface a little distance from the cartilage. Stout silver [illegible] is then passed through the holes, and the fragments are brought accurately into position. Before he brings them together, he provides for the drainage of the joint. A pair of dressing forceps, with the blades closed, are passed through the wound to the most dependent part of the joint at its outer aspect; the instrument is then forcibly thrust through the synovial membrane, the fibrous capsule, and the fascia, until the point of the forceps is felt under the skin; then an incision is next made through the skin, upon the end of the forceps, to allow it to protrude; the blades of the forceps are then opened, and a drainage-tube drawn into the joint. The ends of the wires he twists, and, in

Dr. McColl (Michigan) used the plaster bandages with excellent results. He applied the plaster as soon after the fracture as possible, and enveloped the limb first in cotton wadding or flannel, making extension for 10 to 15 minutes, whilst the plaster was hardening. He allowed his patient up on crutches as soon as possible and did not remove the bandage for three or four weeks.

The immediate application of the plaster splint has not been the rule here in Montreal, but in the cases I have seen this method practised, the result has been good. I had one case this summer of a bar-tender who broke his leg and soon exhibited signs of delirium tremens. The leg could not be kept in splint, so plaster-of-Paris was applied. The delirium lasted for some time and the man was tossing about continually, and sometimes threw himself out of bed. At the end of a month the plaster was taken off and the result was perfect, no deformity or shortening.

Diagnosis of Fracture of the Neck of the Femur.—Prof. Bezzi, after showing in the *Spallanzoni* the difficulties and uncertainties which often attend the diagnosis of this accident, observes that at the Milan Hospital a traditional practice exists of exploring (whenever fracture of the neck of the femur is suspected), the short space between the trochanter and crest of the ilium. In place of considerable resistance which is then produced in the sound limb through the tension of the tensor fasciæ latæ, there is found, when injury has occurred, a deep depression, due evidently to the diminution of the tension of this muscle owing to the approximation of its points of attachment. (*Presse Med. Belge*, July, 1883, quoted in *London Practitioner*, Nov., 1883.)

Treatment of Fracture of the Patella.—The surgical world has lately been much interested in the discussion which has taken place at the London Medical and Clinical Societies consequent on the reading of an address by Prof. Lister before the Medical Society on the *Treatment of Fracture of the Patella by Incision and tying of the fragments together.* The proper mode of treatment of this troublesome fracture has always been a serious ques-

tion with surgeons, and very various are the means recommended to obtain union of the separated fragments. Some think the quadriceps muscle is altogether to blame for the separation of the fragments, and so treat the fracture by methods calculated to pull down the upper fragment; others say that separation is due to effusion of blood and serum, and advocate the withdrawal of this by aspiration. Others, as Prof. Hamilton of New York, say that bony union is not to be desired, as it can rarely be complete, and leaves a weak bone, so they endeavor to get as close a fibrous union as possible by the application of bandages and splints.

Prof. Lister (*Lancet*, Nov. 3, 1883), in his address, relates seven cases of recent and old fractures of the patella treated by incision, and wiring together of the fragments. In all the cases, good bony union and free movement of the joint was the result. He strongly advocates this method of treatment, as the one best calculated to give the patient a useful limb. Six of these cases were shown to the Society, and in all the patella was perfectly natural in appearance and moved freely. Prof. Lister, as early as 1873, treated successfully ununited fracture of the olecranon process of the ulna by wiring the fragments together, and in 1877 first treated fracture of the patella in the same way. He first exposes the separated fragments by a longitudinal incision two inches long, then with a common brad-awl perforates each fragment obliquely, so as to bring out the holes upon the broken surface a little distance from the cartilage. Stout silver wire is then passed through the holes, and the fragments are brought accurately into position. Before he brings them together, he provides for the drainage of the joint. A pair of dressing forceps, with the blades closed, are passed through the wound to the most dependent part of the joint at its outer aspect; the instrument is then forcibly thrust through the synovial membrane, the fibrous capsule, and the fascia, until the point of the forceps is felt under the skin; then an incision is next made through the skin, upon the end of the forceps, to allow it to protrude; the blades of the forceps are then opened, and a drainage-tube drawn into the joint. The ends of the wires he twists, and, in

with strict Listerian precautions. Mr. Turner's case recovered with an ankylosed joint after a long period of suppuration. Mr. Turner also gave a summary of fifty cases treated by various surgeons with a fatal result in two instances, whilst suppuration and ankylosis of the joint frequently supervened. Mr. Lister, who was at the meeting, said that no surgeon should perform so serious an operation unless either prepared himself to dress the patient's wound as required or convinced of the ability of the assistant in charge to do so. He was convinced that, bye and bye, fracture of the patella would be generally treated on the plan he described, in order to secure a perfect joint, without risk, under antiseptic precautions.

Mr. Holmes insisted that the operation could only be justified in some old cases, and not in new ones.

Mr. Heath thought that Mr. Lister's paper before the Medical Society might cause the loss of many knees if not of many lives, because it would stimulate country surgeons to repeat his operation under circumstances which rendered antiseptic treatment impossible. In recent cases, Mr. Heath insisted that the operation was both unnecessary and unjustifiable. (Mr. Heath's new method of treating recent fractures of the patella by aspiration is noticed in the *Retrospect* of June, 1882.)

Mr. Bryant read notes of thirty-two cases of fracture of the patella treated in the ordinary manner and collected at random from the Guy's Hospital register by Mr. Poland. The table showed that injured limbs treated in this way after intervals of 15 or 20 years remained perfectly useful as a result of treatment. With such an experience, he thought the risk to life incurred by Mr. Lister's operation could not be justified.

The general opinion then among English surgeons seems to be that the operation is not suitable in recent fractures, and that though Mr. Lister may be very successful, it does not seem that his most ardent disciples are capable of the same success. The operation is only justifiable in cases of old ununited fracture causing a useless limb and then should only be performed with the strictest antiseptic precautions.

Mr. John Wood, of King's College, has lately (*Lancet*, Nov. 17th, 1883,) had a death from septicæmia following the operation for non-union of fractured patella by the Listerian method. Now, when such a careful and skilled surgeon and so able an anatomist as Mr. John Wood has a failure with Listerism, what will happen to surgeons of ordinary ability and much less experience. It seems to me that this case is sufficient to condemn the operation, in recent cases, at all events. Mr. Wood found that he could not closely approximate the fragments, and if union had taken place it would have been fibrous. The wound was never at any time fœtid.

Dr. McEwan of Glasgow, in the same number of the *Lancet*, reports several successful cases of this method of treating fractured patella, he insists on operating early in every recent case. Fracture of the patella is much rarer here than in England. Why, I am unable to say. In the Montreal General Hospital only some two or three cases have been treated in the last 7 or 8 years.

Prof. Cooper of San Francisco, more than 20 years ago, successfully treated fracture of the patella by wiring the fragments together, and this was done before antisepticism was thought of. He always allowed the wound to heal by granulation.

Lateral Closure of Wounds of Veins.—Dr. Pilcher, in the August number of the *Annals of Anat. and Surgery*, has a very interesting paper on *Lateral Closure of Wounds of Veins*. He has made a number of experiments on the deligation of veins with aseptic catgut ligatures. When lateral ligature was performed, in only one case did a thrombus form. There is, as a rule, union by first intention, and this preserves intact the function of the vessel. Dr. Pilcher recommends this method of ligature for wounds of veins whenever the antiseptic ligature (catgut) can be used and the wound treated antiseptically; otherwise he advises a double ligature of vein and division between.

I lately, in operating on the neck for a large tumor, wounded the internal jugular, and performed lateral ligature with complete success. There was no secondary hemorrhage, and the case progressed favorably to the end. Still, in wounds of veins

of ordinary size—as, for instance, the external jugular—I should be inclined to trust more to complete ligature, with division between, as no one can positively say that the wound will ever, with the greatest care, remain thoroughly aseptic.

Aphthous Vulvitis in Children.—Aphthous vulvitis is a well-characterized disease. It is peculiar to little girls from 3 to 5 years of age; it is rare in private practice, and is observed especially in hospitals. Measles is the principal cause of this affection; it furnishes two-thirds of the cases. Prognosis is good since the introduction of iodoform. The parts should be sprinkled with iodoform powder, and kept apart with pledgets of lint. The internal administration of tonics is a useful adjuvant to the local treatment.—(Arséne Sazaim, *Th. de Paris*, July, 1883; quoted in October *Journal of Cutaneous & Venereal Diseases.*)

Dr. Eugene F. Cordell (*Maryland Med. Journal*, Sept. 1st, 1883) strong recommends the use of a solution of carbolic acid as a *local anœsthetic* in minor surgery. He recommends, before opening an abscess, whitlow, cutting a tendon, or performing other minor operations, that the part be bathed for a few minutes in a five per cent. solution of carbolic acid. This, in some cases, deprives the part entirely of feeling, so that the patient does not feel the knife, and in other other cases considerably lessens the pain.

Alopecia prematura.—O. Lassar has continued his observations on the nature of premature baldness, and has further convinced himself of the communicability of at least the form associated with dandruff. . . . . He considers the disease is spread by hair-dressers, who apply combs and brushes to their customers, one after another, without any regular cleansing of these articles after each time they are used. . . . . Females, he thinks, are less often affected with this form of baldness, because the hair-dresser more frequently attends to them at their own homes, and uses *their* combs and brushes. In order to prevent, as far as possible, the commencement of alopecia prematura, the hair should be cut and dressed at home with one's own implements, and these thoroughly clean. The following treatment of this form of baldness is recommended: The scalp is to

be daily well soaked with tar or fluid glycerine potash soap, which is to be rubbed in firmly for 15 minutes. The head is to be drenched first with warm water, and then gradually colder water; a 2 per cent. corrosive sublimate lotion is afterwards freely applied. The head is then to be dried, and the roots of the hair are to have one-half per cent. of napthol in spirit rubbed into them. Finally, a pomade of 1½ to 2 per cent. of carbolic or salicylic oil is to be used on the head. This treatment has now, in many cases, brought the disease not only to a stand, but the hair has been to a considerable extent restored. (*Berlin. Klin. Woch.*, No. 16, 1883, quoted in *Edinburgh Medical Journal*, Sept., 1883.)

In ordinary dandruff, I have found useful the washing of the head with common or soft soap every other day, and, after drying the head, applying an ointment of equal parts of oleate of mercury (Shoemaker's) and prepared lard.

Carbolized Sawdust as a Dressing.—Mr. H. P. Symonds (*Lancet*, September 22nd, 1883,) recommends the use of coarse sawdust soaked in (1 to 10) solution of absolute phenol and spirit of wine, then allowed to dry that the spirit may evaporate, leaving sawdust charged with carbolic acid. When used it is enclosed in a bag made of several layers of gauze, and applied outside the deep dressing, the usual external dressing being placed over it. The sawdust takes the place of the usual padding of loose gauze which is generally used. Its absorbent powers are very great, and it has the additional advantages of keeping up an even pressure on the divided tissues. Mr. Symonds finds that 14 oz. of sawdust will readily absorb about a pint of fluid. Wood shavings have been used extensively in Germany in the same way with good results.

Sugar as a Dressing for Wounds.—It appears that now there are very few substances that are not used in dressing wounds. Every week something new is used and praised highly for its antiseptic qualities and its cheapness. Bismuth, glycerine, earth, wood shavings, and now we have sugar. Dr. F. Fischer, assistant to Prof. Lücke, in Strasburg Hospital, has used powdered cane sugar extensively as an antiseptic dressing

to wounds. In cases of wounds united by sutures, the sugar mixed with iodoform and naphthalin, is put up in gauze and applied to the part. When the skin is lost it is put directly to the part. The sugar dressing may remain on from 8 to 14 days without the sugar dissolving.

Dr. Windelschmidt, of Cologne, says he has used sugar alone as a dressing with good results and considers it quite as good as iodoform for small wounds. He also says that powdered sugar is a very old popular remedy for fungous granulations, ichorous eczema and erysipelas of the face. Dr. W. has of late discarded the use of sugar in healing wounds, partly because when the patients found out the nature of the powder they ceased to have faith in it, and partly because when they had they treated themselves and so passed from observation. Sugar is aseptic if not antiseptic, and is as good as glycerine when used as a perservative by injecting it into the arteries of the dead animal we wish to keep from decomposing, but it is generally when used for this purpose combined with arsenic and nitrate of potash.

Reviews and Notices of Books.

A Text-Book of General Pathological Anatomy and Pathogenesis.—By ERNST ZIEGLER, Professor of Pathological Anatomy in the University of Tübingen. Translated and edited for English students by DONALD MCALISTER, M.A., M.B., M.R.C.P., Fellow and Medical Lecturer of St. John's College, Cambridge. New York: Wm. Wood & Co.

The text-book of Prof. Ziegler, now added by Wood & Co. to to their library of standard authors, is recognized as one of the best modern works on the subject. It is systematically arranged, written with uncommon clearness, and includes all the most recent researches into the pathology and causation of disease. We know of no similar book which would better convey to the mind of the student the great principles and important facts connected with this most necessary branch of medical learning. It is claimed that on some subjects, such as Malformations, Inflammation, Etiology of Tumors, and Bacteria, it gives a fuller

account of modern teachings and discoveries than has yet appeared in any English manual. We are satisfied, from an examination of these several chapters, that the claim is well founded. It is very well illustrated with numerous original woodcuts. Such books as this do much to popularize the series to which it belongs.

What to do first in Accidents and Emergencies. A Manual explaining the Treatment of Surgical and other Injuries in the absence of the Physician. —By CHARLES W. DULLES, M.D., Surgical Registrar to the University of Pennsylvania, &c. Second edition, revised and enlarged. With new illustrations. Philadelphia: P. Blakiston, Son & Co.

The nature of the contents of this little book will be inferred from its title. It tries to point out with much good sense what can be done in these emergencies by one not possessing the special skill and knowledge of the physician. It is the right kind of book to put into the hands of heads of households, of persons at a distance from skilled assistance, of those in charge of men engaged in manufactures, lumbering operations, &c., to all of whom it may prove of great assistance. The author takes special pains to warn amateurs against the danger they may run of doing too much when they are possessed of a little knowledge—so notoriously a dangerous thing. "The true principle," he says, "is, when the urgency is pressing, to do what is known to be helpful, and when one is not sure, to do nothing."

The Treatment of Wounds as based on Evolutionary Laws.—By PITFIELD MITCHELL, M.R.C.S., &c. New York: J. H. Vail & Co.

Explanation of everything on evolutionary principles is now the fashion. Evolution has been made use of to explain the origin of beings and worlds, as well as social laws and customs, and now it is employed as a basis for the scientific treatment of wounds. The author of this essay, which might be entitled the "Healing of wounds according to the gospel of St. Spencer," after devoting some twenty or more pages out of twenty-seven

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, Oct. 26th, 1883.

T. RODGER, M.D., PRESIDENT, IN THE CHAIR.

Maggots in the Ear.—Dr. Osler exhibited for Drs. McLean and Duncan, of Fergus Falls, Minn., five larvæ of *Musca lucilia* which were removed, with sixteen others (all alive) from the ear of a man aged 24. (*See page* 271.)

DR. OSLER remarked that many such cases were on record, but the large number of larvæ in this one was remarkable. They are invariably in connection with suppurative disease of the ear.

Aneurism of Abdominal Artery and Superior Mesenteric Artery.—This patient, aged 49, a printer by trade, had been brought before the clinical class in the summer session on two occasions. He presented a large aneurism in epigastric region, which projected as a prominent tumor and had considerable mobility. The only symptoms were pain in the back and loins and distress after eating. Had noticed the pulsation for a year, the tumor for only two months. Palpation revealed a curious sausage-like projection from the main tumor, freely movable, and feeling like a dilated vessel. Death took place suddenly from rupture of the sac into the peritoneum.

Dr. Trenholme also exhibited a *pair of ovaries and tubes* removed about ten days ago from a patient in St. Catharines. This being his *sixth* successful case in succession since May last. The ovaries appear to be healthy, but both tubes have been the seat of salpingitis, and are considerably diseased. The patient, æt. 28, has always had more or less suffering at menstruation. About five years ago sufferings increased, and were accompanied by general nervous depression and weakness, suffering especially in her head. About three years ago was under treatment for anteflexion and stenosis, which were relieved, but the treatment greatly intensified her head troubles and general nervous exhaustion. Since that period has been constantly an invalid, often not being able to see her friends, or hear any conversation, remaining in her room alone; sleeps

badly, and often has what she describes as "wave after wave of nervousness," and feels as though she was going mad. The operation was undertaken more with a view to relieve the nerve symptoms than for any pelvic suffering, and so far the patient has made a rapid recovery from the operation, and declares she feels better than before. Dr. Osler took the specimen to report upon at the next meeting.

Dr. Trenholme exhibited a small body, sausage-shaped, about 3 inches long and 1 inch in diameter, somewhat dense structure, and apparently having a capsule, which had been passed by a patient with the following history:—A man, æt. 50, hard drinker, was taken ill with severe vomiting and pains in the stomach and abdomen. Pulse quick, but no elevation of temperature. Bowels coustipated, urine very high-colored and scanty. External and internal treatment failed to give entire relief, and though the bowels were freely opened by purgatives, and the pain alleviated by sedatives, yet the vomiting continued for several days, copious and of a decidedly grumous character. These severe symptoms abated, but still there was occasional vomiting, accompanied by severe colicky pains and great distension of the abdomen. About ten days from the onset of his illness, while defecating, he passed the body now exhibited. The nature of this growth or body is not very apparent to the eye or touch, possibly an organized blood clot or an enlarged gland. Perhaps Dr. Osler, who has it in charge, will give more definite information as to its nature at the next meeting.

Dr. Henry Howard read a paper on "*Division of Labor and the Etiology of Disease.*" He said that, in division of labor, nine out of every ten of our medical men took up some particular specialty, and upon this specialty the profession and the public looked upon them as authorities. This accounted for the rapid strides made in medical knowledge during the last quarter of a century; and not only had this division of labor been confined to the medical profession, but its necessity had been recognized by the agricultural, the mechanical, the commercial, and the travelling classes. After dwelling at some length on this subject

and on the physiology of matter, he said that in diagnosing diseases of the human frame, we find certain physical symptoms or phenomena, and in looking for physical cause, we look for abnormal physiology of parts, or pathological defects, to account for the physical symptoms or phenomena that present themselves. In conclusion, Dr. Howard said: "You may say to me, suppose we know the physiology of all matter, and the pathology of all diseases, what then? Would we be the better able to cure disease or find a remedy for the removal of these diseases? Well, whatever chance we may have when we come to obtain this knowledge, we can do but very little without it. When that time comes, however, I believe the pharmacologist will find the remedy for the disease. I agree with that eminent physicist, Mr. Huxley, when he says, 'It will, in short, become possible to introduce into the economy a molecular mechanism which, like a very cunningly contrived torpedo, shall find its way to some particular group of living elements and cause an explosion among them, leaving the rest untouched.' No wonder that such a man would come to such a conclusion when he so ably and truly describes man. His words are: 'The body is a machinery of the nature of an army; each cell is a soldier; an organ a brigade; the central nervous system, head-quarters and field telegraph; the alimentary and circulating system, the commissariat.'"

Several members spoke approvingly of the new Anatomy Act, and it was suggested that our Society should let the Government know that we would support them against the threatened serious opposition to this Act, which is now being agitated chiefly by political persons. Others of the members thought the less done the better, as the opposition would die a natural death.

Dr. Rodger read the following notes of a remarkable case which occurred in his obstetric practice:—

On the morning of the 10th of October last I was requested to visit a Mrs. L., aged 32, whom it was said had been ill all night with great difficulty of breathing. Found the patient in bed, half sitting, half reclining on her side, and propped up with

pillows. Her countenance was somewhat anxious, face slightly livid, eyes staring, breathing very hurried and short, and complaining of great tightness over the chest and abdomen, with a sense of suffocation. This being my first visit to her at this time, and not knowing that she was pregnant, I at once examined her chest; found heart and lungs normal, but was struck with the size of the abdomen. Her feet and legs were slightly œdematous, but no great amount of swelling of vulva. There had been slight pains at long intervals all night, but the patient said not like labor pains, though she thought she ought to have been confined some time during the month of September, having, as far as she could recollect, menstruated for the last time about the beginning of the year. The size of the abdomen being so much out of proportion to anything I had ever witnessed before, I began questioning as to her condition for some time back. She told me nothing out of the way was noticeable in the size of the abdomen until between the sixth and seventh months; that never at any time could she say she felt any distinct movements of the child, such as she experienced with her other children; that she had suffered considerably at different times from irritation of the stomach—in fact, had often great difficulty in retaining food. A vaginal examination revealed the os to be high up, dilated about an inch, edges tense, but thin; membranes entire, but no presentation could now be felt. Examination of the abdomen gave dulness on percussion throughout; no movement nor outline of the fœtus made out. Could not hear either the heart sounds or placental bruit. With the assistance of the friends present, I changed her position to one which I thought more favorable, and which might assist me in detecting a presentation, but all without any effect whatever. The distress of the patient being so great, I felt that some measures would require to be adopted at once for relief; so I gently dilated the os until I succeeded in passing the greater portion of my four fingers within the uterus, taking care, at this point, not to tear the membranes. Still no fœtus could be felt. Satisfying myself as to the toughness of the membranes, I passed my whole hand between the latter and the walls of the uterus, and endeavored to rupture the membranes with

my finger, but failed. Without withdrawing my hand, I passed with the left a knitting needle, when the rush of waters was tremendous. Continuing my search for the child, my arm acting as a plug in the vagina, I could find nothing in the uterus proper, having passed my hand all around the walls, but, at the upper end or fundus, a circular opening about the size of a silver dollar, edges somewhat thick, and unyielding to ordinary force by the fingers. Passing my forefinger through this new opening, I touched the mouth, nose and eyes of the child, then gradually succeeded in getting in a second finger, when no forehead could be felt—in fact, no head. With the gradual escape of some portion of the amniotic fluid, I found that I could use more force with my fingers in dilating, due to this second uterus, if I may so call it, being brought nearer to my hand. Owing to the alarming condition of the patient at this point, and fearing delay might not serve any good purpose, especially if the escape of the amniotic fluid was permitted, there being a possibility of collapse, I determined at once upon version, and set to work to force my hand into the interior. After considerable resistance had been overcome, both feet of the fœtus were grasped, completing the delivery of a still-born acephalic male child, weighing about six pounds. Fluid Ext. Ergot was given to ensure uterine contraction, and after the delay of a short time, the placenta came away by gentle traction with the hand, followed by slight hemorrhage. The woman was not in a condition to warrant further interference, otherwise I should have liked to have passed my hand and further investigated the interior of the uterus, but feared that possibly such procedure might be attended with bad results.

This is now the sixteenth day since the patient was confined, and I may state that she is doing well, no bad symptoms having appeared so far in the case. I confined the woman three times before, her labors being perfectly natural.

Dr. Rodger had a sketch on the blackboard shewing the relation of the parts before delivery.

Dr. Trenholme remarked with regard to Dr. Rodger's most interesting case, that the position of the opening being at the

"upper part of the fundus," the possibility of tubal or utero-tubal gestation in any of its forms, was excluded. Had it been tubal or tubo-uterine, the opening would have at least not more than 4-5 of the distance from the os to the fundus. It was also impossible that the opening leading from the large cavity containing the waters to that in which the fœtus and placenta were could be a pathological opening, as it was readily dilated, turning easily effected, the fœtus and placenta removed and "good contraction" secured. Hence it must be simply an hour-glass contraction of a uterus containing a fœtus dead for over three months and accompanied by this immense quantity of amniotic fluid. This view is still further strengthened by the fact that the uterine decidua and that of the cavity containing the child *were continuous and one* throughout, there being no membranes to puncture over the aperture where the face of the child presented. The case is a most interesting one and happily conducted to a successful issue.

DR. SHEPHERD was of the opinion that it was a case of tubal pregnancy.

DR. RODGER thought it was a case of hour-glass contraction, but thought there was nothing to preclude its being tubal pregnancy.

DR. CAMPBELL mentioned a case where serious symptoms followed the taking of a three-drop dose of a 1 per cent. solution of nitroglycerine by a patient suffering from angina and advanced mitral disease. Three drops were taken instead of one, as prescribed, in the hope that more benefit would be gained. Shortly after swallowing the three drops a rash like that of scarlet fever came out, particularly on the chest. This disappeared in five or six hours. The tongue was dry, and in twenty-four hours he passed five times his usual amount of urine. The heart beat quickly, but there was no rise of temperature.

DR. H. HOWARD said this agreed with his theory that the blood had nothing to do with rise or fall of temperature, which was alone influenced by the nervous system.

DR. CAMPBELL also spoke of the continued success he is having with nitroglycerine in epilepsy.

DR. OSLER mentioned that he had three cases of *petit mal* where he was using it, so far with decided benefit in only one case.

DR. REED brought up the matter of "Collective Investigation of Diseases," and urged the Society to follow out a plan similar to that adopted by the British Medical Association.

Several members spoke in favor of Dr. Reed's proposal, after which Dr. Hingston proposed that Drs. Reed, Osler and Cameron be named a committee to draw up the necessary questions, etc., with reference to the investigation of Enteric fever. Carried unanimously.

Stated Meeting, Nov. 9th, 1883.

DR. RODGER, PRESIDENT, IN THE CHAIR.

Division of Femoral Artery.—A specimen illustrating a somewhat novel source of injury was sent to the Society by Dr. A. Henderson, of Calgary, N. W. Territories. The deceased from whom the specimen was taken was a cow-boy in the employ of the Stewart Ranche Company and was employed in killing cattle for the C. P. R. construction twenty miles west of Calgary. He was in the habit of carrying his knife unsheathed, hanging to the horn of the saddle, and while taking aim at a steer with his rifle, his horse becoming restive he raised his leg to steady himself when the point of the knife pierced his left thigh about its middle and to the inner side. Profuse hemorrhage followed which proved fatal within an hour. A dissection of the part shewed that the femoral artery had been divided a short distance above where it pierced the adductor magnus muscle. As seen by the specimen, the artery was completely divided by a clean cut, while the vein lying alongside failed to give evidence of the slightest scratch.

Dr. Osler exhibited the following pathological specimens:—

Cancer of Liver, with much-enlarged Glands.—Dr. Phelps, of Chateauguay, N. Y., sent this specimen to Dr. Osler with the following history: "Three years ago the patient, a woman aged 27, noticed a bunch protruding at ensiform cartilage which enlarged slowly. Was treated with blisters and

escharotics. As it still grew she consulted me last spring. I found a nodulated tumor extending from the ensiform cartilage midway to umbilicus and about eight inches wide. It pressed firmly against the margins of the ribs and was but slightly moveable. It seemed to be covered by skin only. Percussion gave a tympanitic note over its whole extent. It could be grasped at lower margin and moved freely but seemed to be attached at the ribs. Up to this date she enjoyed good health, had no pain, only a sense of fullness. Was at a loss for a diagnosis, so sent her to Dr. ——, of Montreal, who said it was an enchondroma of the ensiform cartilage which extended between the sheaths of the rectus muscles. He advised extirpation if it continued to enlarge. In June I was sent for to perform the operation, the messenger stated that another enlargement had appeared further to the right. Drs. Bates, Gay and Furniss, of Malone, accompanied me to her residence where we proceeded to administer ether in order to carefully examine, so as if possible, to determine whether the disease was extra or intraperitoneal. We discovered not only the large right side of the liver but the large mass which proved to be the enlarged mesenteric glands. It is not necessary to say that the operation was deferred till after the patient had climbed the "golden stairs," which took place October 25th, 1883. Dr. Furniss and myself performed the *post mortem*. Skin was cachectic, limbs bloated and abdomen enormously distended. We removed about 40 lbs. of serum from the abdominal cavity. Over the tumor the abdominal walls had been all absorbed excepting the skin and peritoneum. The growth was not adherent in front. The stomach and transverse colon were both underneath of, and attached to, the left lobe of the liver. The pancreas was healthy, the kidneys, ovaries and uterus normal. The thorax was not opened. The disease began as a cancer in the left lobe of the liver, pressing forward and downwards absorbing the abdominal walls and making its appearance at the ensiform cartilage as a nodule. Its overlapping the stomach and colon accounts for the tympanitic note on percussion. The enlarged mesenteric glands and right lobe of liver

made up the second tumor felt by the patient. Death evidently took place from suffocation caused by over-distension with fluid.

Fibroid Disease of the Stomach.—This specimen was sent to Dr. Howard by Dr. Powell, of Ottawa. It was removed from a man aged about 60, not intemperate, but a good liver. He had consulted several doctors who all inclined to a diagnosis of scirrhus of the stomach, as the symptoms pointed that way. The stomach was contracted and much thickened owing to fibroid deposit in the mucous membrane and muscularis.

Laceration of Brain.—This specimen was removed from an hospital patient, a lumberman, suffering from an enlarged spleen and leukæmia for over a year. While in hospital he appeared to be doing well, when one night he suddenly became comatose and died in a few minutes. The *post mortem* revealed extensive laceration of the brain substance from hæmorrhage.

Ovarian Cysts in an Infant.—Taken from a child of ten weeks shewing cystic disease of both ovaries.

Dr Alloway exhibited a "Jannison's Uterine Irrigator" which he had been using for some time past, and which had given him more satisfaction than any other instrument devised for the same purpose. It consisted of a flexible metal tube, so bent that it formed a third arc of a circle, the diameter of which latter was twelve inches. On the outside of this tube ran another of much larger calibre, but not so long, the space between the tubes answering the purpose of providing for an immediate return-stream from the uterus. He related the history of a patient who, having expelled a 2½ month's decidual mass into vagina received an intrauterine injection of warm carbolized water from a fountain syringe, armed with an ordinary hard rubber tube, which did not admit of the immediate return of the fluid. About ¾ of an hour after injection, the patient was seized with pain over the region of the left broad legament, chill and faint feeling, followed by elevation of temperature (102°F.) and pulse 110 and severe paroxysmal attacks of dyspnœa. After the administration of a hypodermic of Battley she recovered from pain and symptoms. Dr. Alloway attributed the condition of his patient to the entrance of the solution for a short

distance of the left Fallopian tube, that slight hyperæmia of the delicate lining of the tube would follow the irritant, and in this way account for the pain and other reflex nervous symptoms manifested. He did not think the symptoms due solely to destension of the uterine cavity by the fluid, as there was no expression from the patient of even discomfort, at time of injection. He thought it of little importance what term would be used to designate the condition; it was the cause of the apparently alarming symptoms which were of interest to him, and which he thought resulted from the use of a tube which did not provide for an immediate return-stream from the uterus. He had injected the uterus under the same circumstances, many times before with the same kind of imperfect tube, but had never witnessed such a condition. He thought probably it would be well to limit injection in such cases. to those in which the discharge were fœtid; and this was one reason why he brought his experience in the matter before the notice of the society, with Jannison's tube however, he would feel perfectly safe under all circumstances.

Axis Traction Hook.—Dr. Alloway also exhibited an 'Axis Traction Hook" of his own device. He claimed that the hook answered all the purposes of Tarnier's instrument when passed into the lock of any ordinary forceps and traction made by the hook alone. Traction could be made in any direction pleasing to the operator, and the hook could be used in this way whether the head was arrested at the brim or low down in the cavity of the pelvis. Dr. A. used the hook almost solely with Simpson's short forceps, and found that the handles of the forceps and those of the hook came when applied into such convenient relationship, that more power, if necessary, could be exerted, than with Simpson's long forceps, without the hook. Dr. A. related the history of a very interesting case where he first used the Traction Hook. The patient had been, some eighteen months before, operated on by Dr. Roddick for the removal of a large ovarian cyst (40 pounds). The walls of the abdomen, so far as the muscular structures were concerned, did not unite, or the line of union had become absorbed, and

allowed an enormous ventrel hernia to take place. When seen at three months' gestation the whole of the intestines and loose adnexa came down in a horn-like pouch between her legs. They had to be replaced and sustained by a suitable truss. During labor almost complete anteversion of the uterus would take place at every pain, and the condition was quite uncontrollable. The axis of the pelvis and that of the uterus were almost at right angles to each other, so that the patient could never have delivered herself unaided. Dr. A., though a firm believer in Tarnier's principle, alluded to the great cost, complex nature, difficult application, and trouble of keeping clean, of Tarnier's forceps, which would tend greatly to prevent the instrument coming into anything like general use. That his simple inexpensive instrument would in many instances prove serviceable when Tarnier's instrument was not at hand.

Dr. Trenholme quite agreed with Dr. Alloway as to the uselessness of the first tube he spoke of, and that he had done well to cast it aside. Dr. Trenholme, however, would go further, and maintained that to inject the uterus, using any manner of tube after the contents had escaped into the vagina and been removed, was an unwarrantable proceeding, and fraught with danger, as the case related shewed. Uterine irrigation was seldom called for, and ought not to be resorted to, save when the decomposing contents, as revealed by the offensiveness of the discharges, shewed that there was danger of putrid absorption. Dr. Trenholme's experience in abortions enabled him to speak decidedly on this subject.

Dr. Trenholme said that the instrument exhibited by Dr. Alloway did not afford one single advantage possessed by Tarnier's forceps. In the first place traction by Dr. Alloway's hook was made at the lock, far from the points or blades, and then the shortness of the handles gave no power to engage the head in the axis of the brim as could so easily be done by Tarnier's. For his part he had used the Hodge modification of the long French forceps in all high operations with ease and success in cases where delivery by the forceps was warrantable; for we must not forget that there is a limit to the force

which cannot be expressed. With the patient on her back and these long forceps, we can with perfect ease engage the head in the brim. The left hand sustains the handles, while the right hand over the lock brings down the head with all the force we would be warranted in using. When this fails, turning should be resorted to so as to open the shortest diameter of the child's head to the antero-posterior diameter of the mother's pelvis.

Dr. Campbell said that the uterus after abortion very seldom needed washing out. Has known colic to follow an injection into the vagina for leucorrhœa. Once saw serious symptoms and death follow an injection in a woman who had recently been confined.

In reply to Dr. Trenholme, Dr. Alloway felt from his experience in the case recited, that if there was no fœtor to be detected in the discharge, and if a uterine tube similar in design to Jannison's was not at hand, it would be better not to inject at all. But if there was evidence of decomposition within the uterus, he would recommend the use of such a tube as the one he used, or better, a common elastic catheter. The solution he was using at present was ℞ parts of corrosive sublimate.

Obstetrics.—Dr. Trenholme related the following case:—Was sent for last Monday by a *confrère* to a woman in labor with her third child. Two physicians had failed to deliver with the forceps. He found the os fully dilated; antero-posterior diameter at brim was 3¼ inches. Had had a natural labor with her first child; the second had to be delivered with forceps. Dr. T. found the child was lying diagonal to the abdomen. He proceeded to turn, his hand first feeling the promontory of the sacrum bulging out; there was also hour-glass contraction a little above the os, and again near the fundus, which caused great difficulty in moving the child. However, after some time he succeeded in delivering all but the head, which Dr. Armstrong opened, as by no safe efforts could it be loosened.

Dr. T. said the trouble was caused, not so much by the deformity, as by the two spasmodic contractions. He had seen a similar case before, where, from repeated powerful attempts to

deliver with the forceps, the uterus around the os was bruised into a pulpy mass, causing the death of the woman.

DR. CAMERON had seen a case something similar, requiring evisceration, owing to ergot having been wrongly used to hasten a tedious labor from early escape of liquor amnii. No amount of traction was of any avail.

DR. ALLOWAY thought that cases where the waters broke early and caused spasmodic contraction on the child were not very unusual.

DR. ROSS thought the cause in Dr. Trenholme's case was obscure. He did not believe that spasm alone could resist strong efforts at traction, especially as the head was found very large. He thought it should hardly be called hour-glass contraction. Had only seen two cases of hour-glass contraction, and in both it was after the birth of the child, and where the placenta was retained above.

DR. TRENHOLME replied by saying that he thought it not unreasonable to put the difficulty down to spasm, as in his previous case the woman had plenty of room, yet was unable to deliver with forceps on account of spasm gripping the child.

DR. RODGER agreed with Dr. Ross that other causes appeared to be present to account for the difficulty.

The following resolution of condolence was passed by the Society, to be sent to the family of the late Dr. Trudel:—

"That this Society desires to express its sense of the great loss sustained by the profession and society generally in the death of Dr. E. H. Trudel, whose long and honorable career as a man and physician secured to him the consideration and esteem of the citizens generally, and whose high scientific attainments and facile mode of expression enabled him for many years to fill the chair of Obstetrics in the Montreal School of Medicine with distinction to himself and advantage to the students."

—A remarkable case of skin-grafting is reported by Dr. H. H. Gardner, of San Francisco, in the *Lancet* of that city for October. A man received an extensive burn on the legs, the ulcers remaining represented 287 square inches. In the month of March 118 grafts were planted, in April 169, in May 80, June 127, July 95, and in August 15. The healing in June was at the rate of 2½ inches per diem, and the average daily amount for the six months was 1½ square inches. When shown at the Society there were but 10 inches left to heal.

Extracts from British and Foreign Journals.

Unless otherwise stated the translations are made specially for this Journal.

Early and Late Operations in Morbid Growths.—Let me instance, as an illustration of my meaning, carcinoma of the female breast. This disease, as is well known generally begins in the substance of the mamma as a small nodule or tumor, hard on pressure, and the seat of occasional pain of a shooting or darting nature. The woman is 45 years of age. As the morbid action advances, the growth enlarges, the pain increases in severity and constancy, and, by and by, retraction of the nipple is noticed. Gradually the growth becomes more and more fixed in its situation, and if now the glands in the axilla—naturally so diminutive as to be scarcely distinguishable—be examined, they will be found more or less enlarged and indurated. The diagnosis is not difficult. The case is one of scirrhus, nothing else. A careful examination of the breast, and a careful consideration of the history of the case, leave no doubt as to its true character. If the patient is under 40 years of age, or from 25 to 40, with a hard, movable nodule, the seat of occasional darting pain, especially annoying during the menstrual period, unaccompanied by change in the nipple, in the surface of the breast, and in the axillary glands, we assume that the neoplasm is a fibroma or adenoma, and unhesitatingly assure the patient that excision of the growth will eventuate in a complete cure.

In carcinoma of the breast, the honest and enlightened surgeon does not wait for involvement of the axillary glands or serious structural disease. He knows that the patient's safety, present and prospective, lies in the early use of the knife and in thorough excision. He urges the importance of prompt interference, and assures the patient that, if the operation be properly done, it will probably eventuate in a permanent cure, or, if relapse occur, that there will be a comparatively long exemption from suffering. Everybody knows what the result of excision of the mammary gland in ordinary cases of cancer is; how rarely the disease is completely removed, and how few women

live beyond eight, ten, or twelve months after such interference. In all such cases, cancer-cells have invaded the neighboring structures beyond the reach of the knife, especially as ordinarily employed, and serve as foci of new neoplasms. It makes one's very soul ache to see so many young women doomed to endure the most frightful suffering in carcinoma of the breast for the want of a correct early diagnosis and the thorough ablation of the diseased structures. Of all the agony I have ever witnessed, there is none at all comparable to that arising from this form of malignant disease of the mammary gland in its more advanced stages.—*Abstract of paper read by Prof. S. D. Gross.*

Dr. A. T. Cabot on the Treatment of Empyema.—A Lister dressing properly applied fulfils the required conditions more thoroughly than any other which I have seen in use. The method of application which I have found best is as follows:—The tubes, of which I generally use two, side by side, are arranged so that they barely project within the chest wall, and the outer ends, after being securely fastened with safety pins and adhesive plaster, are cut off as close to the skin as possible. A handful of loose gauze wrung out in an antiseptic solution is placed around and over them, and over this a piece of mackintosh large enough to project in every direction beyond the gauze beneath it. Over this again are placed many (12 to 15) layers of dry gauze, and, lastly, a sheet of cotton batting to provide for equal pressure. This whole dressing is held in place by a gauze or flannel bandage, some of the turns of which should go over the shoulder to prevent its slipping down. The loose gauze next the tube catches and holds the discharge, which, in a favorable case, is reduced to almost nothing after the third or fourth dressing, and soon becomes serous. This rapid diminution of the discharge under antiseptic treatment, and the fact that it speedily becomes serous in character, was pointed out some years since by Professor Lister; but he did not mention, and I have never seen elsewhere described, the great advantage of this form of dressing in favoring the expansion of the lung and obliteration of the cavity. This latter action of the dressing is due to the method in which the mackintosh is applied. This

rubber layer, impervious to air, overlaps the gauze beneath it so that its edges are held closely applied to the skin by the elastic pressure outside. How closely it clings to the skin can only be appreciated by one who has frequently removed these dressings. When, now, air is forcibly driven out of the chest by a cough, it lifts the edge of the mackintosh somewhat and escapes; but as the elastic outside dressings immediately press the mackintosh again to the side, the air which could lift it from within cannot get beneath it from without. It acts, in short, as a valve, allowing air to escape from under it, but not to get back again.—*Boston Med. and Surg. Journal.*

A New Dressing for Wounds.—From Prof. Bruns, of Tübingen, we receive a fresh addition to our means for carrying out the after-treatment of wounds, in the form of a preparation which he calls "wood-wool," and which he recommends to surgeons (*Berl. Klin. Woch.*, No. 20). Fine-grained wood in the form of splinters and shavings, such as are largely employed in paper factories, according to Bruns, is the kind of material to be used in preparing the dressing which is called wood-wool. Pine wood is preferred, and especially the *Pinus pieca*, which is poorer in resin and of coarser grain as compared with the wood of other pines and firs. The further preparation of the wood shavings and splinters consists in their reduction to a state of finer division by being rubbed through a wire sieve, then dyed, and finally impregnated with various antiseptic substances. That considered best is a half per cent of corrosive sublimate and 10 per cent. of glycerine (the percentage apparently referring to the ratio between these substances and the wood-wool). The advantages of such a dressing are believed to be manifold. Compared with ashes and turf, it is absolutely clean, fresh, and of white color, and is soft and pliable like ordinary wool, and, withal, of extraordinary cheapness. It possesses, in virtue of its contained resin and ethereal oils, certain antiseptic properties, and is so easily adapted to the wounded parts and of such elasticity that a uniform and equable pressure is easily obtained. Its principal property, however, is its extraordinary power of taking up fluid: in this it excels all other

forms of dressings; it absorbs twelve times its own weight of fluid, so that ten grammes of dried "wood-wool," after complete saturation, weigh 130 grammes. Simple sawdust absorbs only three to four times and a half its weight of water; ashes only nine-tenths. This dressing has been in use by Bruns for half a year, and he has every reason to be greatly satisfied therewith. With the exception of one case of erysipelas, no secondary accidental wound-diseases were met with.—*Med. Times & Gazette.*

A New Operation for Spina Bifida.—Dr. A. W. Mayo Robson thus describes his operation in the *Brit. Med. Journal*:—

"I made a vertical incision on each side of the tumor, about half an inch from its base, through the skin, and then very carefully dissected the integuments from the meninges until I reached the laminæ of the vertebræ; this required very careful dissection, as the membranes left were so thin as to be perfectly translucent; the fluid was let out out by puncturing with fine scissors, which were also used to cut away the redundant membranes. The cauda equina was fully exposed, lying on the floor of the spinal canal. I now had two folds each side, each fold being of a different width, the two inner meningeal folds three-fourths and half an inch respectively, and the two skin flaps of the same width; but whilst the wider meningeal flap was on the right, the wider skin-flap was on the left. Thus, when sutures were applied, the lines of union were not opposite. Acting on the same principle as is carried out in uniting the peritoneum, I brought together the serous surfaces of the arachnoid by several sutures, so as to completely shut off the spinal canal. Mr. Mayo had, in the meantime, been kindly dissecting (under the antiseptic spray) the periosteum from the femur and frontal bone of a rabbit which he had just killed. This periosteum I now placed, with its osteogenic layer undermost, over the closed meninges, and carefully sutured it to the periosteum of the laminæ on each side, and to the bony margins above and below. After this the skin was sutured, a layer of protective applied, and a pad of salicylic wool placed over the wound. The whole operation, which occupied more than an hour, was performed under the

eucalyptus air. Catgut ligatures were employed, and the instruments and sponges were well carbolized. On the second day, the nurse, in applying the napkins, displaced the dressing; but although the skin wound was slightly opened, there was no formation of pus, and no slough came away; in fact, through the small opening, I could see that granulations had sprung up from the superficial surface of the interposed periosteum. The child has thriven, and has not had a single bad symptom. As yet I cannot feel any bony crackling, but the skin is level with the surface, and the case is practically cured; if bone form, however, the covering will be all the firmer, and the spinal canal will be physiologically perfect.

Modern Circumcision.—The official circular of instructions, Jan. 10, '83, says the *Med. Press and Circular*, issued to the Israelitish communities of Baden, sets forth that the only persons who are to be permitted for the future to perform the rite of circumcision shall be such as shall be authorized by the Jewish Supreme Council. 1. The knife must be freshly polished and the forceps properly purified. 2. The quadrangular pillow employed, as well as the sausage-shaped ring, must be freqnently renewed, and, before every circumcision, covered with new gutta-percha tissue or new sarsanet. 3. The operator, immediately before the operation, must carefully wash his hands with soap, and cleanse the nails with a good hair brush, taking peculiar care that no dirt be allowed to remain under the nails, more especially under those of the thumbs. The hands must, in addition, be washed in a 5 per cent. solution of carbolic acid. The operator is no longer to suck the wound, nor irrigate it with wine ejected out of the mouth. Instead of this, the blood is to be removed by gently wiping the wound with pledgets of purified boracic lint dipped in wine. The wound is to be closed by being enveloped in a strip of 10 per cent. boracic lint. The further removal of fluids and blood-clots is only to be effected by means of a new sponge previously soaked in a 5 per cent. carbolized solution or by salicylized lint. A medical man must be immediately called in if hæmorrhage be considerable, and cannot be at once stopped, or if it be from an artery. Such authorized persons are forbidden to perform the rite, if suffering from any infectious disease, and until complete recovery has taken place.

CANADA

Medical and Surgical Journal.

MONTREAL, DECEMBER, 1883.

DOCTORS' SIGNS.

A doctor must have a sign. What shall it be? A door-plate, brass or silvered, painted wood or painted glass, or shall it be a fan-light transparency, or a pestle and mortar with his name on it, or shall it be a solid monumental stone? We recognize three groups—the necessary, the accessory and the superfluous signs. In England and, as a rule here, a door-plate 10×4 inches, brass or silver-plated, is thought sufficient. Occasionally it reaches mammoth dimensions; we know of two 2×2 feet with five inch letters. In the Atlantic cities neat silvered plates are in vogue. In the West it is more common to see the name painted on a wooden or metal slip and placed on the house wall. Narrow glass transparencies in the front window catch the eye frequently in Boston and New York. Beyond the simple door-plate, signs are accessory or superfluous. Some of these are harmless, even necessary, others indicate more or less accurately the professional standing of the possessor. Where a house stands back from the street, an accessory sign may be needed—placed on the gate, or on an upright, or on a tree, as is common in Western cities, or on a fan-light above the door, or even on a lantern as in Winnipeg. There is no special objection to any of these, but in large towns they are scarcely needed. Fan-lights are often very loud and vulgar. We heard a significant remark by a well-known American physician when passing a door in this city over which was a large transparency with the name and number Doctors —— 1710, (Surgeons) 'irregulars, eh'? There is one accessory sign the use of which in this city we should like to

see discontinued. We refer to the narrow printed posters pasted upon the side of the house wall. They are commonly used after change of residence; it does not look well, and professional visitors to the city have been not a little scandalized at the practice. Superfluous signs are not often employed by men in good standing, but young physicians and new comers are tempted to use them. Any special designation on the sign, as oculist, aurist, or gynecologist is, to say the least, bad form, and often indicates the quack or irregular. In many of the associations of the United States the use of such designation in the press or on the door-plate precludes from membership. Special qualifications on the door-plate or sign are unpardonable, such as the following from a neighbouring city: Dr. ——, M.D., Edinburgh (Honours) M.R.C.S., Eng., L.A.H., Dublin (!) A pestle and mortar over the door is a frequent sight in the French quarter of this city and is not inappropriate where the doctor dispenses his own medicine. The latest novelty we know of in the way of signs is what may be called the monumental, introduced lately into a Candian city. A fine block of granite is chosen, such as would be suitable for the base of a tombstone, and the doctor's name cut in large letters on either side. During the lifetime of the doctor, the block is used as a carriage step in front of the pavement.

Happy the man whose reputation is such or whose local habitation is so well known that he needs no sign! This is sometimes the case in country places and small towns, not often in cities. We know of one such in a prosperous Canadian city. Grandfather, father and son have been in 'the old stand' so long that to the inhabitants of the locality the doctor's house is amongst the things which have always been. The patients' entrance is in a side street and a small porch protects the visitor. The steps are well worn and the native grain is everywhere visible in the wooden surroundings. There is neither bell nor knocker and the door presents interesting, and so far as we know, unique evidences that votaries to this Æsculapian shrine have not been lacking. On the panels at different heights are three well-worn places where the knuckles of suc-

cessive generations of callers have rapped and rapped and rapped. The lowest of the three, about three feet from the floor, represents the work of 'tiny Tim' and 'little Nell,' so often the messengers in poorer families. Higher up and of less extent is a second depression where 'Bub' and 'Sis' have pounded, and highest of all, in the upper panel a wider area, where the firmer fists of the fathers and brothers have, as the years rolled on, worn away the wood to nearly half its thickness. Such a testimony to the esteem and faithfulness of successive generations of patients is worthy of preservation.

MOTOR CEREBRAL LOCALIZATION.

An important contribution to this subject has been made by MM. Charcot and Pitres in the May, June, August and October numbers of the *Révue de Médicine*. The articles are based on an analysis of nearly 200 cases of cerebral cortical disease reported since 1878. The review is divided into four sections. In the first, the lesions outside the motor zone are considered; in the second, the affections of this region; in the third, irritative lesions, with partial (Jacksonian) epilepsy; and in the fourth, the contradictory observations are studied and criticised. The cases have been analyzed with great care, and in many instances illustrative figures are given. It would occupy too much space to give even a brief summary of the work under the different sections, but the conclusions, as summarized at the end, may be given as follows;—I. All lesions of the cortex cerebri in man do not give rise to motor troubles. The surface of the brain may be divided into two distinct parts,—the *non-motor* regions, affections of which are never followed by paralysis; and the *motor* region, destructive lesions of which always produce permanent paralysis of the opposite side of the body. 2. The non-motor zone embraces (*a*) all the pre-frontal region—orbital lobe and the 1st, 2nd and 3rd frontal convolutions; (*b*) the occipito-parietal region; (*c*) the temporo-sphenoidal lobe. 3. The motor zone embraces only the ascending frontal and ascending parietal convolutions, and their extension on the median surface, known to French writers as the para-central lobule. 4. Total

hemiplegias of cortical origin are produced by extensive lesions of the ascending convolutions; partial paralyses (of cortical origin) are produced by limited lesions of the same convolutions. Of the latter may be distinguished: (*a*) the brachio-facial monoplegias which coincide with lesions of the lower half of the ascending convolutions; (*b*) the brachio-crural monoplegias, which coincide with lesions of the upper half of these gyri; (*c*) the facial and lingual monoplegias, depending on very limited lesions in the lower part of the motor zone, particularly of the ascending frontal; (*d*) the brachial monoplegias which depend on lesions limited to the mid-region of the motor convolutions, particularly the ascending frontal; (*e*) the crural monoplegias, depending on limited lesions in para-central lobule. 5. Whether general or partial, the paralyses produced by destructive lesions of the cortex are permanent, and, after a certain time, are followed by descending degeneration of the pyramidal fasciculi and permanent contracture of the paralysed muscles. 6. Irritative lesions of the surface may give rise to epileptiform convulsions (cortical or Jacksonian epilepsy), clearly distinguished from ordinary epilepsy, beginning with a motor aura and confined to a group of muscles or one-half of the body, or the convulsions may become general. 7. As a rule, the lesions which induce epileptiform convulsions are in the cortex, and are in, or close to, those centres which, if destroyed, would cause paralysis of the muscles convulsed. The lesions, however, may be either in the motor or non-motor areas.

The authors conclude by stating that the doctrine of cortical localization in man is based on an analyses of many hundred observations, and that it is perfectly satisfactory. There is not a single demonstrative contradictory observation. Those which are given as such certainly do not stand the criticism of MM. Charcot and Pitres. They make the strong statement that there is not a single strict observation on record of a destructive lesion outside the motor area which has produced phenomenal paralysis, and, on the other hand, there is not a strict observation of a destructive lesion of the motor regions which has not caused a permanent paralysis on the opposite side of the body.

UNDERGRADUATES' DINNER, MEDICAL FACULTY, McGILL COLLEGE.

Last year the medical students decided to change somewhat the character of the annual festivity which had been known in the school for years—tradition does not say how long—as the "Footing Dinner." The professors and graduates were asked to co-operate and the experiment was in every way successful. This year it was even a more brilliant affair and not a little was added to the enjoyment of the evening by the presence of student representatives from other colleges. We object to the committee calling this the *second annual* dinner of the Undergraduates. It is more properly the 32nd, or for ought we know the 42nd, and last year did not see a new custom inaugurated, but a very old one, modified and improved. Moreover, at many of the old dinners the junior members of Faculty and Graduates were present, and the only difference now is that the affair is somewhat more elaborate, the toasts more formal—and aquatic, not vinous.

The affair was held at the Windsor on the 7th, Mr. R. F. Ruttan, B.A., in the chair. After some excellent introductory remarks and the loyal toasts, the chairman gave the University, Governors, Professors and Graduates.

Hon. Justice Mackay replied for the Governors, and referred to the warm interest which they took in their oldest and most prosperous Faculty.

Dr. Johnson, Dean of the Faculty of Arts, replied for the Professors, and Dr. Grant, of Ottawa, in a stirring and able speech, for the Graduates.

"Our Benefactors." a new toast at medical school dinners in Canada—to be a routine one we hope ere long in all—was proposed by Dr. Howard, the Dean, who spoke of the great benefits conferred on the school and indirectly on the entire profession by the munificent gifts of the Hon. D. A. Smith and others, It was extremely gratifying to think that these gifts were tributes to the memory of their late Dean, Dr. Campbell, whose name would ever be associated with the first endowment of the school and with the new wing to be erected to his memory at the Hospital.

Mr. Thos. Workman, in replying to the toast, bore testimony to the good behavior of the students who passed his house early and late on their way to the school. He rejoiced at the success of Faculty, and in speaking for the benefactors he hoped that what had been done was a trifle in comparison with what might be expected in the future. McGill College might rest satisfied that money would be forthcoming, and as regards the medical school he trusted that many whom he addressed would live to see the endowment just ten times the present amount.

The General Hospital was given by one of the vice-chairmen, Mr. Guy F. Palmer, and responded to by Mr. Andrew Robertson, the President, who spoke in hopeful terms of the prospects in the near future of a new hospital worthy of the city.

"Sister Colleges," proposed in a neat speech by Mr. John Elder, B.A., was replied to by the student representatives of the different colleges.

Mr. Spence, from the Toronto school, spoke well, but the burden of reform in the course of study oppressed his soul, and his remarks on the subject, though sound enough in the main, were rather out of place. Mr. Fierheller, of Trinity, made a capital speech, and elicited considerable merriment by humorous remarks about the Women's College, Toronto, and the difficulty the students would have experienced in electing a representative if one had been invited (an oversight by the way which the committee should see to next year). We hope his picture represents harmless after dinner exaggeration. Messrs. Cumberland, Blackmer and Valin replied for Kingston, Bishop's and Laval. The Class '84 was proposed by Mr. Henri Lafleur, B.A., in some well chosen remarks, and replied to by Mr. J. P. McInerney in a speech which gave promise of considerable ability as a speaker.

Dr. Osler proposed the "Freshmen," which was responded to by Mr. Wilkinson, B.A., in a very pleasing and telling speech. His hits at the eccentricities of genius in the senior students as experienced by freshmen were exceedingly good. He bore testimony to the kindly way in which the older students treated the inexperienced who came among them for the first time.

The "Ladies," proposed by the Chairman, was replied to by Mr Wyatt Johnston. The health of the Chairman was proposed by Dr. Rodger and enthusiastically drunk, after which the company dispersed.

The *menu* was exceedingly well arranged—many of the quotations were admirable—as, for example, under Benefactors, one from O. W. Holmes—

> "God bless you, gentlemen, learn to give
> Money to colleges while you live."

In addition to numerous graduates residing in the city, we were greatly pleased to see Dr. Grant of Ottawa, Dr. Brigham of Philipsburg, and Dr. Hill of Ottawa.

THE SCHOOL DINNERS.—The tenth annual dinner of the Toronto School took place at the "Queen's" on the 13th Nov. and was a most successful affair. A liberal complexion was given by the presence of the Hon. Edward Blake and Hon. Alex. Mackenzie. Mr. McInerney replied for the undergraduates in Medicine of McGill. The Trinity dinner took place on the 22nd. Mr. Graham, a fourth year student, was present as a representative from McGill. Bishop's College dinner was held at the Windsor on the 12th.

THE GENERAL HOSPITAL.—A building is in course of erection for the nurses, and when completed, the brick annex, now used by them, will be devoted to scarlet fever, diphtheria, and erysipelas.

The division of the clinics into a junior and senior class this session is giving great satisfaction; the amount and variety of teaching material is above the average.

Dr. Bell, the Superintendent, has sent in his resignation, to take effect May 1st. He will resume practice in the city.

LONDON (ONT) SANITARY CONVENTION.—By no means the least valuable part of the work done by the Ontario Board of Health consists in the diffusion among the people of a knowledge of sanitary laws, by the publication and distribution of suitable pamphlets and the holding of conventions in different parts of

the country. One of the most successful of these meetings was held in London, on the 16th and 17th ult., under the presidency of Dr. Rae. Dr. Hunt of New Jersey and several other prominent Americans came over from the Detroit meeting, and added not a little to the general interest. Many valuable papers were presented, among which we may mention "On Disinfectants," by Wm. Saunders, Esq.; "On the Hygiene of Rural Schools," by Inspector Dearness; "On the effect of Mill Dams on Public Health," by Dr. Arnott of London, Ont.; "Sewerage," by Prof. Galbraith of Toronto University and Dr. Oldright.

Obituary.

—The death of Dr. Hilton Fagge at the early age of 45 is a serious loss to the profession in London and particularly to Guy's Hospital, at which he was one of the hardest workers and most successful teachers. For a year or more it was known to himself and intimate friends that he was the subject of aneurism, but he continued to attend to his duties quietly, and died suddenly on the night of the 20th November. For twenty years he had been connected with Guy's, and after holding junior appointments became full physician in 1880. In the school he was Lecturer on Pathology and Demonstrator of Morbid Anatomy. He was a prolific writer on medical and pathological subjects, and the past 18 or 20 volumes of the Hospital Reports contain many able articles from his pen.

—It is not often, fortunately, that we are called upon to record the death of a student during term. Indeed, considering that there are over 400 medical students in the four schools of the city, many of them exposed in a special manner to contagion, the mortality among them has been, in the past 10 years, very slight. Mr. John L. Howey, of Eden, Ont,, died of typhoid fever in the General Hospital on the 30th ult., after an illness of six weeks. He was in his second year in McGill College and one of the ablest men of his class, having taken a high position in the first year examinations. His sad death at the early age of 20 is deeply deplored by his fellow students, with whom he was a great favorite, and by his teachers who had recognized in him a man of more than ordinary promise.

Personal.

Dr. Playter, of Toronto, has removed to Ottawa.

Dr. W. H. Burland has removed from Montreal to Florida.

Dr. Dowling, M.P.P. for North Renfrew, has been unseated.

W. A. Shufelt, M.D. (McGill, '81), passed the R.C.S., Edin.

G. Carruthers and J. C. Bowser (Class '83, McGill), have passed the R.C.P., Lond.

Dr. Burnham, of Toronto, was married on the 14th ult. to a daughter of the Hon. Sidney Smith, of Cobourg, Ont.

Medical Items.

—Dr. Depaul, Professor of Obstetrics in Paris, died on October 22nd, aged 73.

—Mrs. Scott, wife of the late Prof. Scott, died on the 22nd ult., scarcely six months after the death of her husband.

—We regret to see that a death from chloroform in the dentist's chair took place a week or two ago in Berlin, Ont.

—The Homewood Retreat for insane persons opened at Guelph on the 15th. With Dr. Lett and such a staff of directors we predict for the institution a prosperous career.

—In the three by-elections at present progressing in Ontario, doctors are among the candidates. In West Simcoe, Dr. Wylie; in West Middlesex, Dr. Roome; and in Cardwell, Dr. Robertson.

—Mr. James Shuter, one of the assistant surgeons at St. Bartholomew's, died from the effects of an overdose of morphia accidentally taken by mistake for a saline mixture.

—Dr. Ruhdorfer reports an unusually obstinate case of hiccough, lasting three months and resisting all remedies, finally cured by the injection of three centigrammes of hydrochlorate of pilocarpin.

Brantford City Hospital.—Mr. John H. Stratford has offered the City Council to build an hospital at a cost of $12,000, to be called by his name. He further offers to give $400 a year for maintenance.

Communicability of Phthisis.—The Collective Investigation Committee of the B. M. A. received 1,078 replies to this question. Of these, 673 were negatives and 261 affirmatives. Of these a large proportion (192) refer to husbands and wives or near relatives, and it is worthy of note that in 130 of these it is stated that "no family history of phthisis existed in the partner to whom the disease was supposed to be transmitted."

CANADA

MEDICAL & SURGICAL JOURNAL

JANUARY, 1884.

Original Communications.

FEMORAL HERNIA, RIGHT SIDE.

OPERATION AFTER NEARLY THREE DAYS' DELAY—RECOVERY.

By J. CAMPBELL, M.D.C.M., and L.R.C.P., Edin., of Seaforth, Ont.

(Read before the Canada Medical Association, at Kingston, September, 1883.)

Gentlemen,—Thinking the notes of the following case may be of some interest to the members of this Association, I beg leave to present them for your consideration.

I was called at 2 o'clock a.m., on the 24th of Dec., 1882, to see an old lady who said she was suffering from "cramps." The pain was referred to her right groin, and upon examination I discovered a small tumor, which, after some manipulation, I diagnosed to be femoral hernia. As she was suffering severe pain I relieved her with a hypodermic injection, using one of Weyth's pellets of morphia and atropine, which I always carry. I then enquired into the history of the case, and set to work to return the hernia without the aid of chloroform, which I could not procure until daylight without trouble or delay.

The following is the story of the case:—Mrs. T., whose age is 57 years, is a native of Scotland, but has lived 12 years in Seaforth. She has had a rupture of her left side for 12 years, but never had anything wrong with the right side before. She is a heavy, fleshy woman, and upon the previous evening, about 10 o'clock, when going upstairs to bed, she was taken with severe pain in the right side, followed by vomiting, which lasted until relieved four hours afterwards as already stated. The temper-

ature was normal, the pulse slightly accelerated. I tried taxis cautiously, getting the husband to raise the lower part of the body, throwing the weight on her shoulders, a manœuvre which I had often found succeed, but all was of no avail. I remained with her all night, and at 8 o'clock a.m Dr. Scott was called in. He also tried the taxis, but failed, and as she was easy, advised delay. Saw her repeatedly during the 26th in company with Dr. S., using injections, taxis and anæsthetics at intervals, as symptoms seemed to require and our judgment would dictate—pulse and temperature all this time remaining normal and the pain and vomiting being allayed by the hypodermic injections which were repeated from time to time.

During the night of the 26th symptoms began to grow more grave, and I prepared for an operation, which I was willing to perform whenever such a course was decided upon. Dr. Scott still counselled delay, and Dr. Gunn, of Brucefield, having called upon me accidentally, I took him in to see our patient. This was about 11 o'clock a.m. The patient was vomiting greenish matter every five or ten minutes, and the temperature which had hitherto been normal, now rose to 101°, while the pulse reached 120. Dr. Gunn was in favor of an immediate operation, and as the friends wished to see Dr. Gounilock, he also was called in and was in favour of operating at once. I had been looking forward to this decision and had everything in readiness. It was, however, decided that when the patient was put under chloroform Drs. Gunn and Gounilock should each try the taxis for the last time, and failing, I would operate without allowing her to recover from the influence of the anæsthetic. The taxis failed, as was expected, and we began the operation. Dr. Gounilock attended to the chloroform, Dr. Scott sponged, and Dr. Gunn assisted me with the instruments. As there was a doubt in the minds of my consultees as to whether it was femoral or inguinal hernia, I consen ted at their request to make incisions which would suit either case, namely, one parallel to Poupart's ligament and another at right angles to the former, having the neck of the sac under the junction of the two incisions. We made our incisions carefully. There was a large amount of adipose tissue which complicated

matters very much. We used the director as we neared the sac, which, when reached, welled or rolled up clear and shining. We resolved not to open the sac, so passing in the forefinger, which had been carbolised, I found the tense edge of Gimbernaut's ligament well defined. We then passed in the hernia knife with its flat side towards the finger in the usual manner, and turning the cutting edge towards the ligament incised it with a sawing motion, after which we found little difficulty in emptying the sac and returning the bowel, which went back with a gurgling noise. We used antiseptic precautions from first to last, with the exception of the spray. The wound was well sponged out with carbolic lotion and brought together with deep wire sutures, carbolised silk being used to bring the lips in apposition, a piece of lint soaked in carbolic lotion was laid on the wound—a figure of eight bandage put on—an opiate given, and the patient allowed to rest. The bowels moved naturally five hours after the operation; this was the first time since the attack, notwithstanding the injections of warm water, warm olive oil, and other means that had been repeatedly used during the three days she had been under treatment. Everything in short went well until the fourth day, when it was found that a quantity of pus had collected at the lower edge of the wound, the rest having healed by first intention. The temperature which had resumed the normal after the operation now rose to 101°, the pulse to 120, and the patient became restless. The pus was evacuated and the part sponged with carbolic lotion, a good dose of quinine was given and repeated at intervals until the temperature became normal, which was three days afterwards. The wound was kept scrupulously clean, and carbolic dressings used, and the patient made a good recovery. At this stage I regretted that a drainage tube had not been used as I believe this complication might have been prevented. The part of the wound where the pus had formed had to heal slowly by granulation, after which a well-fitting double truss was procured, and the patient resumed her household duties and has done well ever since.

REMARKS.

It may be thought strange that we had so much difficulty in deciding as to whether it was a case of femoral or inguinal hernia

—all my consultants leaning to the belief, to the very last, that it was inguinal hernia—and being only convinced when they felt Gimbernaut's ligament with the finger; but the fact was that I had very great difficulty at arriving at the diagnosis I did, and I certainly had a better chance than any of them, having seen the case from the first, and remaining hours with her. I will give my reasons for arriving at the conclusion I did.

Upon examination, I found a tumour about the size of a small hen's egg, tender to the touch, and below Poupart's ligament. It seemed to be high up for the saphenous opening, and the woman being very fat, it was difficult indeed to diagnose. The tumour was longer in the transverse than in the vertical diameter. The femoral artery could be felt to the outside of the tumour, comparing the position of the tumour when I raised it up with the spine of the pubis, I satisfied myself that it was outside of that prominence (which was, however, very difficult to make out). I could not make out the tendon of the long adductor on account of the fat. There was no impulse upon coughing and the tumour had a soft, doughy feel, as fat would have when compressed by skin and subjacent tissue. Moreover, it was higher up than any femoral hernia we had ever examined. These were the puzzling points in the case. Of course the suddenness of the attack, the severe pain, the complete obstruction of the bowels and the existence of a tumour, all taken together, eliminated everything else but hernia. The only question was—What kind of hernia was it? inguinal or femoral? There were other puzzling factors in the case, such as the following: There never was any impulse upon coughing—there was an absence of the usual elastic feel—the position of the tumour (which had turned up over Poupart's ligament), and last, the length of time that elapsed before urgent symptoms set in, which seemed to point to the fact that the bowel could not have been occluded through its entire diameter. If in connexion with the foregoing we consider the success which attended the operation, after a delay of three days, we must consider it a rather unique case indeed, and worth reporting. I may state that I believe a small piece of omentum must have been included in the stricture, that this was in front of the bowel, and that the gut could not have been occluded throughout its whole diameter.

I believe if any undue force had been used in taxis, we would not have had our patient to-day. We raised the tumour gently, drew it to one side and slightly downwards, and then made moderate pressure as directed, always bearing in mind the direction in which the pressure ought to be exerted. I am not an apostle of force, and would not like to be called upon to operate after repeated and too forcible attempts at reduction had been made.

In conclusion, I would say that I never wavered in my diagnosis as to its being a case of femoral hernia, and only used the incisions I have mentioned at the request of the gentlemen assisting me, knowing that by reflecting back the angles made by my incisions, I could reach the constriction, no matter what kind of hernia it proved to be. I was gratified, however, at finding my diagnosis correct, and the operation successful.

OUR LONDON LETTER.

(From our Special Correspondent.)

LONDON, Dec. 17, 1883.

I happened to be visiting St. George's Hospital recently when a most interesting case was brought on the table by Mr. Timothy Holmes, the well-known surgeon. The patient, a woman of about thirty years, unmarried, first noticed some two years ago a couple of small painful lumps on the radial side of the forearm. They were thought to be connected with the radial nerve and were removed. The pain, however, continued and the hand became contracted, so that Mr. Holmes thought it advisable to amputate at the elbow joint. In a few months the patient returned, complaining of intense pain in the stump. He now excised portions of the median, ulnar, and another nerve (probably the musculo-cutaneous) but with only temporary relief. Now he decided as a *dernier resort* to amputate at the shoulder joint, and this operation I saw him perform. Mr. Holmes feared, however, that the mischief was still more deeply seated, and that even this extreme measure might not be followed by permanent removal of the symptoms.

While sojourning in Glasgow last month I visited the Royal Infirmary on two or three occasions at the invitation of Dr.

McEwen, the famous osteotomist. He kindly afforded me the opportunity of witnessing his operation for knock-knee on two patients, one a boy of ten years, the other a young woman of eighteen.

The condition known as genu valgum or knock-knee is very familiar to every practitioner, although its pathology and treatment perhaps are not always so well understood. Briefly, the deformity is now known to be due to the following changes in connection with the knee joint: In the first place a stretching occurs of the internal lateral ligament, and of the fascia on the inner side of the joint; secondly, on the outer side there is a corresponding shortening of the external lateral ligament, fascia lata, and biceps tendon; and thirdly, on account of the unequal pressure to which the outer condyle and outer tuberosity of the tibia are subjected, these parts become atrophied, while the development of the internal condyle is allowed to go on uninterrupted, and hence the undue prominence which it assumes. All these circumstances, then, combine to cause this deformity. It must not be forgotten, however, that the constitutional condition known as rickets is largely to blame for these changes, and is in fact the primary cause of genu valgum in the vast majority of cases. Thus in large cities such as Glasgow, where the lower classes are ill-fed and ill-housed, and where the parents are notoriously intemperate, nearly every third child one meets in the slums is either bow-legged or knock-kneed. Undoubtedly, however, there are cases where no constitutional defect can be discovered, that is to say, where no evidence is apparent elsewhere in the individual. Here usually one limb only is deformed, and the cause may often be traced to something in the occupation of the person, being compelled perhaps to maintain a constrained position for hours together, the weight of the body coming on one limb.

As to the treatment of knock-knee much can be done in the case of young children by change of air, better diet, the administration of the lime salts in some form, and the application of a suitable support to the limb. Of the last mentioned it will be found that the most useful apparatus consists of a flattened steel bar extending on the outer side of the limb from the hip to the

foot, and attached to the boot. Towards this the knee should be gradually drawn by means of straps properly padded. In very young children, and for a time in all cases, there is no necessity for a hinge opposite the knee, and the limb has consequently to be kept straight, and it is better to treat one at a time when both are affected.

But in practice, and more especially in out-door hospital practice, how imperfectly are these measures carried out. Some of them are absolutely impracticable in the case of poor people. Hence in children under these circumstances the deformity grows with age, and by the time they reach the eighth or tenth year the changes in the joint have become so confirmed that nothing short of operative interference can be of any avail. I took some trouble to examine carefully four cases of knock-knee over a certain age, attending one of the Orthopœdic Hospitals which I recently visited, and where the treatment is purely instrumental, but I found in no case (after months of treatment) that decided improvement which would lead one to expect a permanent cure of the deformity.

About seven years ago (it may be longer), Ogston of Aberdeen began the treatment of knock-knee by sawing through the elongated internal condyle subcutaneously, displacing it upwards, and in that way allowing the limb to be straightened. This operation, however, has the great objection that the joint is invaded, and indeed serious consequences have followed its performance. Chiene of Edinburgh modified Ogston's operation by employing a chisel in place of a saw, and breaking off the condyle obliquely down to, but not through, the cartilage, so that the latter was bent but not broken when the limb was brought to the straight position. This method has much to commend it and is still preferred by a few surgeons. But the operation which is now acknowledged by nearly all to be the safest, and to give the most satisfactory and permanent results is that practised Dr. McEwen, of the Royal Infirmary, Glasgow, and which I was afforded the opportuity of seeing that surgeon himself perform. McEwen is a staunch disciple of Lister, and insists upon it that no antiseptic precaution (not excepting the spray) shall be overlooked during

the performance of his operation. He proceeds as follows: The patient being anæsthetized, and the Esmarch bandage applied, the limb is laid over a sand pillow, the inner side of the knee joint being uppermost. The tubercle of the adductor magnus (which by the way can be distinctly felt in any limb not inordinately fat) just above the internal condyle is then carefully made out, and directly over this with a small scalpel, a vertical incision is made reaching to the bone. This incision should be long enough barely to admit a chisel or osteotome about three-quarters to seven-eighths of an inch in breadth. The chisel is passed down, the scalpel acting as a guide, and then turned at right angles to the bone. With the aid of a wooden mallet the osteotome is made to penetrate the bone in two or three directions, but in the same transverse line, until resistance is no longer felt, when it is withdrawn. Now by grasping the leg near the foot and forcibly inverting it, the limb will be found to come to the straight position with a snap. If the operation be properly performed the femur will have been divided transversely above the condyloid portion, and free from the epiphyses. The periosteum on the outer half of the bone will remain *intact* and will be simply stretched when the limb is brought into position. There should be no hemorrhage, beyond a little venous oozing, excepting occasionally when a muscular branch is divided. The wound need not be sutured, but simply covered with protective, and the ordinary antiseptic dressing. The splint used consists of a long external and short posterior piece, a foot rest being attached to the former. The original dressing is left undisturbed for two weeks, excepting of course in the event of hemorrhage, continued pain, or high temperature. At the expiration of six weeks usually the limb is put up in paraffin or plaster of Paris and the patient allowed up on crutches.

Dr. McEwen's results have been so far most gratifying. One of his colleagues, however, has recently had a death from pyæmia after an osteotomy for knock-knee, but the exact cause of the misfortune I could not ascertain. It has been alleged that the deformity returns after this operation and some surgeons oppose it on that account. But in many of these cases of so-called re-

lapse, the fair presumption is that the bone has not been thoroughly divided. I happened the other day to notice in one of the London hospitals a case in point. McEwen's operation was being performed. After a very timid use of the chisel the limb was manipulated with a view to straightening it, but the characteristic "snap" did not follow. However, it was at length made apparently straight, but undoubtedly at the expense of the ligamentous structures. The deformity in that case will of course *relapse*, and the operation will get the discredit.

From Glasgow I went to Edinburgh, where I spent three days, but the only operation I happened to witness was an ovariotomy by the celebrated Keith. There was nothing special in the case beyond the fact that the woman was very weak from a recent pleurisy, and the operation was consequently done rapidly. I find that Dr. Keith uses all the ordinary antiseptic precautions, with the exception of the spray, which he objects to chiefly on account of its chilling effect. He is very fond of the glass drainage tube, and used it in the case in question. In the great majority of his cases he treats the pedicle with the ordinary hot iron, but on this occasion he ligatured with Chinese silk treated precisely in the manner described in my last letter. I saw nothing in his method of operating that was at all singular. The results of this great ovariotomist, however, continue to be as marvellous as ever, notwithstanding the fact that many of his operations are now performed in the Royal Infirmary, where special wards have been set apart for him.

By the way the new Royal Infirmary is a magnificent institution. It is built on the edge of the open space known as the "Meadows," and consists of a number of buildings arranged on the pavillion plan. The medical and surgical wards are under separate roofs, and in fact in different parts of the grounds, so that there is no communication between them. Each ward has its own nurses' room, kitchen, splint room, and surgical apparatus distinct; and, what struck me as very novel, a comfortable room for the dressers and clinical clerks, where convalescent patients are attended to, and where the clerks can work up their cases without risk of being disturbed. Every member of the staff, like-

wise, has a cozy little retiring room in the near neighbourhood of his wards, so that for a wonder they were not quite forgotten by the Management when devising their plans. I may be doing some worthy institution an injustice when I make the statement, but I know of no other hospital where the individual comfort of the staff has ever entered into the calculations. It is to be hoped that the excellent example set by the Management Committee of the Edinburgh Royal Infirmary will not be lost on similar bodies.

Adjoining the Infirmary is the new Medical School in connection with the University. The building is still incomplete in many parts, although the lectures are being delivered now for the first time this winter. No pains are being spared to make it one of the most complete institutions of the kind in the world. Every member of the Faculty has had the planning of his own department, and the consequence is that the arrangements for teaching are simply perfect. For example, the chairs of Physiology and Materia Medica have each in connection with them at least a dozen rooms for laboratory and other purposes in addition to the general lecture rooms. Each professor has his own lecture and retiring rooms, and the former are all intended to seat at least five hundred students. The dissecting room is said to be the largest known, and I should say the most admirably arranged. The building has already cost three hundred thousand pounds, and when the plans for the library and various museums have been worked out, the figure will not fall much short of half a million sterling. T. G. R.

Hospital Reports.

Medical and Surgical Cases Occurring in the Practice of the Montreal General Hospital.

CASES OF DYSENTERY—UNDER THE CARE OF DR. OSLER.

During the past five years ending May 1st, there have been very few cases of this disease admitted to hospital, and it does not appear to have been at all prevalent in the city. During this period only 11 were treated, while in the five years previous 77 cases of acute dysentery were admitted. The following cases

illustrate severe types of the disease. Case 1 presented rather anomalous bowel symptoms for dysentery; tenesmus was not a prominent feature, nor were the stools characteristic. Case 2 was admitted in my absence, and was treated by Dr. Molson as dysentery with secondary abscess formation.

CASE I.—*Dysentery—Sloughs in the Colon and Rectum of unusual extent—Death.*

P. C., Italian, aged 35, admitted July 4th, 1883, with fever and abdominal pain. Was a sailor, had come from Glasgow, and about a year ago had had a somewhat similar attack in the East. No satisfactory account of the onset of present illness could be obtained. On admission the temperature was 102°; pulse about 100; face flushed and anxious looking; abdomen tender on pressure, particularly in right side; no diarrhœa. Examination of thoracic organs negative. The case was thought to be possibly one of typhoid fever. Summarized, the course was as follows during the three weeks in hospital: Abdominal pain was a prominent feature, and the general tenderness persisted. The abdomen was moderately full, never greatly distended. There were no spots. Two days after admission diarrhœa set in—four stools. On the 8th, 10th, 12th and 14th he had from six to ten a day. From the 15th to the 21st there were no evacuations; and from the 21st to the 26th, when he died, the diarrhœa was severe. The stools were loose, usually copious, thin, and brownish in color, containing at times mucus in flakes, and on several occasions blood. On the whole, the characters were not those of dysentery, nor did he seem to have severe tenesmus. The spleen was enlarged. There were no special cardiac or pulmonary symptoms. The pulse was weak and rapid, never dicrotic. The face constantly wore an anxious expression, indicative of great suffering. The mind remained clear; no delirium.

Autopsy.—Moderate wasting. Nothing of note in thoracic viscera. In abdomen, the large bowel was injected and looked unusually thick, and was firm to the touch. The general peritoneum was not involved. When slit open, the large intestine presented a picture of the most extensive dysenteric affection.

The cæcum and colon were covered with large, irregular, greyish-white sloughs, ranging in size from a five-cent piece to a half dollar, ragged on the surface, and all of them extending deep into the submucosa, and in some cases to the muscular coat. Scarcely any of them had separated; in fact, there were only two or three small ulcers. The process was most advanced in the cæcum and ascending colon. There were only a few patches in the sigmoid flexure. In the rectum, about three inches from the anus, was a slough of extraordinary size, measuring about three inches in length, an inch and a half in breadth, and fully one inch in thickness, greyish-yellow and necrotic, and beginning to break away at the edges and surface. It extended to the peritoneal coat, which was inflamed and hæmorrhagic. There were no smaller sloughs in the neighborhood.

CASE II.—*Dysentery—Abscess of Liver pointing externally—Death.*

Robert S., aged 43, admitted Sept. 12th with severe diarrhœa. Was in hospital several days in May with *gastritis a potú.* Gave a history of diarrhœa for some time, watery stools; not certain about the presence of blood. No account of tenesmus. Was feverish on admission, pale, pulse weak and irregular, skin moist, and patient looks sinking. Examination of chest negative. In abdomen, there is a soft, fluctuating tumor in the epigastric region, just inside the costal margin, tender on pressure, dull on percussion, and continuous with the liver, which did not seem enlarged. Spleen dulness normal. Abdomen a little full, not tender. The diarrhœa continued on the 13th and 14th, and he became weaker, and died on the 15th, without presenting any additional symptoms. Temperature subnormal after the first day; no sweats; no chills. The treatment consisted of stimulants, with sedative and astringent injections.

Autopsy.—Body fairly nourished. In making the preliminary incision, an abscess cavity was opened in the epigastric region. The right rectus muscle was infiltrated, and the pus had reached the subcutaneous tissue. The abscess was evidently connected with the left lobe of the liver, and was in process of perforation

through the abdominal wall. Below it was bounded by the transverse colon. The general peritoneum was not involved. On removal of the liver, the upper surface of the right lobe looked smooth and natural; towards the suspensory ligament there was a thin layer of lymph. The abscess cavity occupied the region of the organ just below the suspensory ligament, more in the left than in the right lobe, and was about equal in size to the closed fist. The pus was thick and creamy-yellow in color, and mixed with shreds of necrotic liver substance. The walls were rough and sloughy. Anteriorly, the abscess had destroyed the peritoneum and had perforated the abdominal wall, forming the prominent tumor noticed during life. In the centre of the right lobe was a second, smaller abscess, the size of an apple. The portal vein and its branches were normal, with the exception of one branch going to the left lobe, which contained a small mural thrombus. Small bowel not diseased; mesentery normal; veins healthy. The large bowel was extensively involved; cæcum thickened, deeply injected, and the mucosa thickly covered with yellow-brown sloughs. The ascending and transverse colon presented numerous ulcers, from some of which the sloughs had scarcely separated. In the descending colon and sigmoid flexure the process was not so extensive. No changes of importance in other organs.

MEDICAL CASES UNDER THE CARE OF DR. ROSS.

Mitral Regurgitation—Dilated Hypertrophy—Repeated Dropsies and Hydrothorax—Efficient action of Digitalis—Pulmonary Congestion—Death—Autopsy.

W. W, aged 40, a cabman, was admitted to the hospital November 24th, 1883, suffering from obstinate vomiting, shortness of breath, and swollen legs. He had been in the hospital three times previously to the present. The first admission was on the 29th September, 1882; he had then great shortness of breath. This, he stated, had come on very suddenly about a month before. Any slight exertion, or the recumbent position, caused him severe dyspnœa. He had been a heavy drinker, and at date of admission had just got over a spree. Had been

exposed to cold and wet; had been subject to rheumatic attacks in his left shoulder for three years.

When admitted, the patient's face, feet and eyes were a little swollen and œdematous. There was considerable distension of veins on the left side of neck. Pulsation seen in epigastric region; no pulsation in mitral area. On palpation, impulse felt over the whole precordial region. Apex beat, on close examination, is felt in 4th interspace, below the nipple. Heart very rapid, and a blowing, systolic murmur is heard, with its maximum intensity just beneath the nipple, and to its outer side, also transmitted beyond the axillary line, and heard faintly at the back, near the spine. There is slight irregularity of the heart's action; no increase in dulness upwards. At the base the sounds are muffled. Percussion note over lungs, clear in front and behind. Below the 3rd rib, on right side, breathing is feeble. A few moist râles are heard near left axilla, behind. Liver is somewhat enlarged. Pulse rapid, very weak, irregular and intermittent; no difference in the two sides. Urine, 22 ozs.; specific gravity, 1012; normal color, and contains no albumen. Bowels constipated; Tr. Digitalis ♏ ii ordered every two hours.

Sept. 30th.—Patient a little easier; breathing not so difficult, but is not able to lie down.

Oct. 2nd.—Not so well. Breathing short, and considerable lividity about hands and chest, also cyanotic in face. Radial pulse almost extinct, although heart's impulse is strong. Very great irregularity of the heart. Some œdema of feet and hands. Tr. Digitalis increased to ♏ v every three hours.

Oct. 3rd.—Patient is easier, but dyspnœa still intense, and great lividity of feet and legs. Considerable œdema of feet. Radial pulse scarcely perceptible. Percussion note at right apex is slightly hyper-resonant down to third rib; below this point it becomes dull. Breathing is exaggerated above third interspace, and below that is very weak; behind, dull up nearly to spine of scapula. There is diminished fremitus and resonance, and the breathing is scarcely audible over the dull area.. Breathing over left lung somewhat exaggerated; no dulness, except at extreme base, where the breathing is weak. Impossible to count radial pulse. Heart beating 160 per minute.

Oct. 10*th.*—Patient much easier during past two days; 80 ozs. urine passed in 24 hours. Heart steadier, but still a little irregular; dullness at right side, behind, still present, but over a smaller area. Breathing more distinct. Heart murmur persistent, but not as low as on admission.

Oct. 14*th.*—Heart still a little irregular, but only beats 68 per minute. Murmur is scarcely audible, having lost blowing quality. Slight shade of dulness at right base, for one inch vertically. Tactile fremitus again present. He is passing 80 ozs. urine. Digitalis diminished to ♏ v thrice daily.

From this time he improved rapidly, all dropsy disappeared, and he was discharged October 19th.

After being discharged he remained idle for a month. At the end of that period he resumed his work as cab driver, and continued driving until two weeks before the 10th February, 1883. He was re-admitted to the hospital on the date mentioned, suffering from shortness of breath, cough, swelling of the feet and legs, and vomiting. He had then been sick for two weeks. He attributed his illness to exposure to cold. The attack began by being chilly while standing on the ice, followed by vomiting and shortness of breath. In three days his legs began to swell. Had a constant desire to vomit. For ten days was unable to lie down. Sense of suffocation does not trouble him while quiet and in the sitting posture. Heart strong, diffuse pulsation over cardiac area but cannot feel the apex beat. Dulness not increased. Action very rapid—over 140 per minute and intermittent. Apex systolic murmur as before. Can hardly distinguish pulse at wrist. Lungs—right base dull, feeble breathing, diminished resonance. Urine contains no albumen.

Feb. 12*th.*—Since admission patient vomited continuously. Unable to lie down. No change in physical signs. Tr. digitalis ♏ x, spts. chloroform ♏ x, every four hours, also a hypodermic of morphia gr. ⅛ over stomach.

Feb. 13*th.*—Vomiting much relieved by the hypodermic and at night patient felt much better. Some vomiting to-day. Pulse better. Dropsy increasing.

Feb. 18*th.*—Very much better. Vomiting ceased. Colour

good. Sense of suffocation has disappeared. Heart improving. Pulse much better.

Feb. 21*st.*—Continued improvement. Heart's action stronger and slower. Passing 120 ozs. in 24 hours; no albumen. Dulness at right base, with bubbling râles. Left lung normal.

Feb. 25*th.*—Dropsy almost gone. Lungs as in last note. Heart irregular, but stronger, not over 100.

Feb. 28*th.*—Dropsy has disappeared.

March 10*th.*—Patient going about the ward. Still a little dulness in right base with râles. Heart still irregular and murmur present, though faint. Patient left hospital to-day. Digitalis stopped and Dialysed Iron ♏ xv, thrice daily, substituted.

On July 16th, 1883, he was re-admitted with same old complaint of swollen legs and feet, dyspnœa, etc. Systolic mitral murmur, and irregular heart's action as before. Lungs normal. Tr. Digitalis ♏x. given ter die, and he was discharged on the 20th, four days after admission, and much improved.

When last admitted—Nov. 24th—the patient was very restless, frequently changing position, getting up and sitting down every few minutes. Persistent vomiting. Passing very little urine the day before admission, and none whatever to-day. Legs are only slightly swollen, but cold, clammy and blue. Clear note over bladder. Pulse small, weak, and irregular. Systolic mitral murmur. Dulness to upper border of 8th rib in right lung, with feeble breathing over same area. Infusion Digitalis ʒ i, spts. Chloroform ♏ x, every four hours. Also, 4 ozs. gin.

Nov. 27*th.*—During night passed seven ounces of urine, and this morning passed eight ounces. It is of a bright reddish color (blood). Heat and nitric acid shows a slight trace of albumen in the urine, which was probably due to the amount of blood present. Had a very restless night. Pulse almost imperceptible.

Nov. 28*th.*—Feels much easier, can now lie quite still in bed. Slept fairly well last night. Swelling in legs much diminished —feet quite warm. Passed about same quantity of clear normal urine as yesterday—no blood or albumen.

Nov. 29*th.*—Passed 46 ounces of urine—no albumen. Pulse

rapid and weak. Not much improved. Feels better and rests well.

Dec. 1*st.*—To-day patient presents a subicteroid appearance and yellowishness of conjunctivæ. Urine not colored.

Dec. 12*th.*—Passed good quantities of urine till two days ago. Legs swollen again. Spitting up bright blood. Front of chest wet cupped. Expectoration of thickly glairy mucus tinged with blood. The upper lobe of left lung, fine crepitant sounds heard in latter half of inspiration. Sub-icteroid look, cough, and slight hæmoptysis continued, accompanied by great dyspnœa and prostration. Œdema rapidly increased and the legs had to be punctured. He sank and died on the 16th December.

Autopsy.—Large-framed man; general anasarca. A couple of quarts of serum in peritoneum, two or three pints in each pleura, and several ounces in the pericardium. Heart hypertrophied and dilated; thick yellow clots in right chambers. Weight of organ, 610 grammes. Valves normal; aortic segments competent; mitral segments a trifle thickened at eges; no vegetations. Mitral orifice over six inches in circumference; tricuspid orifice nearly seven. The chambers were all dilated, and there was moderate hypertrophy of the walls. Muscle of fair color. Apices of papillary muscles fibroid. Aorta smooth. Coronary arteries not atheromatous. Lungs showed moderate emphysema at anterior margins; general brown induration; a large infarct at base of right lung. No pleural adhesions. Cyanotic induration of spleen, which was double the normal size. Kidneys slightly enlarged, coarse and hard; three healing infarcts in the left. Catarrh of stomach and bowels. Liver undersized, a little granular in the surface, hard and firm, and in early stage of cirrhosis.

Mitral Disease—Rapid general Dropsy—Complete relief to symptoms from Digitalis.

F. R., aged 18, was admitted 7th December, 1883, suffering from general dropsy and orthopnœa. Health fairly good till early in summer, when some shortness of breath was noticed. About July last had swollen feet at night. Within the last three

weeks the legs had become much swollen, and shortness of breath has been becoming very troublesome. For several days before admission was unable to leave her chair day or night. Has lately coughed a good deal. Ten years ago patient had pneumonia, and a mitral murmur was then noticed. Never had rheumatism. On admission, orthopnœa, labored breathing, moderate cyanosis, and considerable general anasarca. Heart quite tumultuous; a blowing systolic murmur at apex; pulse small, irregular, and intermittent. Both bases of lungs flat on percussion—the right to the level of the scapular angle; the left some distance higher. Breathing feeble generally over these areas, but on the left side, in the upper part of the dull area, the respiration is very distinctly bronchial. Urine, 18 ozs.; specific gravity, 1022; no albumen, no casts. Ordered Potass. Bit. gr. xv, Spts. Chloroform. ♏ x, Infus. Digitalis 3i; to be given thrice daily.

No diuretic effect was produced from the 8th to the 12th, on which latter day the amount of urine remained at 18 ozs.; but on the 13th it was 50 ozs.; 14th, 85 ozs.; 15th, 130 ozs.; 17th, 105 ozs., from which date it gradually diminished, but even now (7th Jan., '84), it is as high as 84 ozs. Coincident with the diuresis, the dropsy as rapidly disappeared, and the hydrothorax was completely removed. The pulmonary percussion became normal throughout, and the natural respiration was everywhere heard. The pulse remains small (about 80), and but slightly irregular. The general condition has improved in proportion. Patient is quite cheerful, breathes well, and sleeps soundly in the recumbent posture.

Remarks. — These two cases afford excellent examples of the good results to be obtained from digitalis in the dropsy of heart-failure. In the first case, the apparently desperate condition of the man is hardly realized from the description. On three several occasions he was rescued from a state of extreme danger and great suffering by prompt treatment, and was restored for a considerable time to comparative comfort and activity. The autopsy showed absence of any disease of the valve curtains, but great enlargement of the auriculo-ventricular opening. It is quite probable that, had he been a more carefully-living man,

his life might have been still further prolonged. It will be noticed that in both these cases the kidneys remained, almost throughout, free from any evidences of secondary disease. This fact was utilized in the prognosis of each case, a favorable opinion (for temporary improvement) being based upon this important observation.

Correspondence.

THE OTTAWA "HOUSE OF BETHLEHEM."

(From our Special Correspondent.)

The "House of Bethlehem" of Ottawa, under the care of the Grey Nuns, has lately been receiving a great deal of attention. This charity is a sort of branch of the House of Mercy Lying-in Hospital, and is almost solely devoted to receiving infants born in the hospital. Since its establishment in 1879, the rumors concerning its high death-rate and the care of the inmates have not reflected to the credit of the institution. The City Council recently decided to investigate the matter, and the City Health Officer was directed to prepare a report, five other physicians being appointed to act with him. The report of this committee was well deliberated and prepared with care. They considered that the objects of the charity were unattained, and recommended that, in its present state, it should be discontinued. The following are the conclusions arrived at as to the cause of the deaths:

1st, The want of nourishment from the mother.

2nd, The low state of vitality and oftentimes diseased condition of many of the infants received.

3rd, The location of said institution, in our estimation, not being the most suitable to serve the purpose of the delicate task undertaken, in the great majority of cases of death, we are convinced, has been derangement of the digestive functions, or complications brought about by disorders of that part of the system.

4th, Though exonerating the ladies in charge of this institution from all blame, believing that they, to the best of their ability, did all that lay in their power to best serve the interest of humanity, we are of opinion, however, that the system itself

is impracticable and faulty, being productive of negative results, so far as attaining the chief object in view, the saving of the infant's life; therefore we would recommend that the House of Bethlehem, as a foundling institution, be closed, and that no children be received there under the present system of dry nursing.

After careful consideration, and as the result of practical experience, we are of opinion that, in order to effect a greater saving of life, it is necessary that the child be nourished at the breast, this method embracing the only certain means of lessening infant mortality.

To this report was appended a second by the attending physicians, reviewing their experience in their official capacity, and also blaming the system of dry-nursing for the mortality. They conclude as follows:

"We succeeded in saving all the children who had the good fortune of being nursed by their mothers for at least the first two or three months of their existence; the two weeks of maternal feeding required of late by the Local Government always proved to be utterly insufficient. The endeavors that we, as well as the sisters, have made to diminish this great mortality, brought us to the conclusion that wet nursing is the only means of obtaining this result and of saving the lives of infants in cities."

The mortality has been—

1879–80	79½	per cent.
1880–81	81	"
1881–82	97	"
1882–83	89	"

In consequence of the above report, the City Council passed a resolution that the institution should be discontinued, and word was sent that no more infants were to be received.

Following upon this, the Grand Jury of the County Court, in their presentment, stated that among the public charities visited were the "House of Mercy Lying-in Hospital" and the "House of Bethlehem," both of which were disapproved of. The former they considered, by aiding women to hide their shame, only encouraged the evil; the latter they advised should be closed, as follows:

"This awful mortality, we were informed, arose mainly from the separation of the children from their mothers, and we cannot urge too strongly upon the proper authorities the urgent necessity for immediate interference by the Government, or, if necessary, by the Legislature, to prevent the countenance of this loss of infant life."

The latest phase of the controversy is a letter in an evening daily paper, presenting the views of a "Catholic Clergyman." It defends the institution on account of the lives saved that would otherwise, he states, be sacrificed, and states that as long as the legal requirements are complied with, they are fulfilling their duty, and can only be prevented by the Local Government. As the Government inspector has annually reported against it, the Government can hardly fail to act when it is brought to their notice. Any further aid from the county or city they cannot now expect.

Reviews and Notices of Books.

A Practical Treatise on Materia Medica and Therapeutics.—By ROBERTS BARTHOLOW, M.A., M.D., LL.D., Professor of Materia Medica and General Therapeutics in Jefferson Medical College, of Philadelphia. Fifth edition, revised and enlarged. New York: D. Appleton & Co.

The fifth edition of this deservedly popular work on Therapeutics contains many very important additions. There is a short but well written chapter on the use of electricity in medicine. Preference is rightly given to the Siemens-Halsken element as being the most suitable for the work of the physician. This form of battery is very durable, and the current generated from it is smooth and uniform. It is much cheaper also than the batteries made on this side of the Atlantic and in England. If medical batteries could be obtained as cheap and as good in this country as in Germany, the profession would soon take up the subject of Electro-Therapeutics. Practitioners cannot much longer afford to neglect the use of such an all-important means of diagnosis and treatment.

Dr. Bartholow gives a clear description of the polar method of

investigation. His remarks on electro-diagnosis, and especially on Erbe's "degeneration reaction" are good.

An account is given—necessarily superficial—of the different diseased conditions that are benefited by the rational use of the *galvanic* and *induced* currents.

The importance of using the galvanometer is insisted upon, but no description is given of Edelmann's instrument, which is the most trustworthy of all.

In the section dealing with the motor depressants we have a very good account of the latest information concerning such agents as curara, nitro-glycerine, muscarine, and quebracho. The pharmacology of these drugs is very fully considered. In no other work in the English language can the same information be found.

The aim of the author to bring his work thoroughly abreast of the times is further evidenced by the fact of the presence of full articles on convallaria, resorcin, chinoline, etc. Hydrotherapy, metallotherapy, and the pneumatic treatment of diseases of the chest all receive more or less attention. Atropine is recommended as a physiological antidote to carbolic acid. Dr. Bartholow says he is indebted to Dr. Post of New York for this observation. The latter administered atropine in a case of carbolic acid poisoning where there was marked contraction of the pupils and failing circulation. The result was successful. Similar success is reported from other quarters, it is said. Dr. Bartholow instituted a number of experiments on animals, and as a result of these he considers it as proved that there is a real physiological antagonism between these two agents. If this shonld prove to be true, it will be a very valuable discovery, for although we possess in sulphate of soda a chemical antidote, its action is too slow in the very acute cases of poisoning to save the patient. We can confidently recommend this work as being an able exposition of the present state of pharmacology and therapeutics.

The Medical Student's Manual of Chemistry.—By R. A. WITTHAUS, A.M., M.D., Professor of Chemistry and Toxicology in the University of Buffalo, and in the University of Vermont, &c. New York: W. Wood& Co.

The scope of this work is best gained by the following state-

ment made by the author in his preface :—" In the preparation of this manual, the Author has striven to produce a work which should contain as much as possible of those portions of special chemistry which are of direct interest to the Medical Practitioner and at the same time to exclude so far as possible, without detriment to a proper understanding of the subject, those portions which are of a purely technological interest. The descriptions of processes of manufacture are therefore made very brief, while chemical physiology and chemistry of hygiene, therapeutics and toxicology have been dwelt upon."

The book has been well and carefully prepared, and can be safely recommended to the notice of all students in this branch of medical education.

The Treatment of Wounds, its Principles and Practice, General and Special.—By LEWIS J. PILCHER, A.M., M.D., Member of the New York Surgical Society. With one hundred and sixteen engravings. New York: Wm. Wood & Co.

The above is one of the best practical works which have been added to the list of 'Wood's Library.' Its author is well known as a thoughtful surgeon, and one who has contributed many articles of value to the current American literature. The all-important subject of wound-treatment is considered in a really scientific and impartial manner. Dr. Pilcher never advises the slavish following of the methods of any one man, but rather the carrying out of the management of injured parts by strict reference to our knowledge of the natural processes of cure and the means we possess for advancing these. Careful attention is of course given to the discussion of the relation of micro-organisms to wound-disturbances and the closely related subject of asepsis and antisepsis. The third section, dealing with wounds of special regions, abounds with practical hints, and furnishes a complete repertory of special dressings. We had much pleasure in the perusal of several of these chapters, and congratulate the author upon the successful manner in which he has succeeded in bringing his subject-matter together.

The International Encyclopedia of Surgery—A Systematic Treatise on the Theory and Practice of Surgery. By Authors of various Nations. Edited by JOHN ASHURST, Jr., M.D., Professor of Clinical Surgery in the University of Pennsylvania. Illustrated with chromo-lithographs and woodcuts. In six volumes. Vol. III. New York: Wm. Wood & Co.

The third volume of this truly great work has now been for some time in the hands of the subscribers. It fully sustains the high reputation of the two former, and the encomiums passed upon them. The admirable articles contained in each one deserve a much more extended notice than we are able to give them here. Several of the most interesting departments of Surgery are discussed in the present volume, as may be judged of from the following list:—Injuries and Diseases of the Muscles, Tendons, and Fasciæ, by P. S. Connor, M.D. Injuries and Surgical Diseases of the Lympathics, by Edward Bellamy, F.R.C.S. Injuries of Bloodvessels, by John A. Liddell, A M., M.D. Surgical Diseases of the Vascular System, by John A. Wyeth, M.D. Aneurism, by Richard Barwell, F.R.C.S. Injuries and Diseases of the Nerves, by M. Nicaise, M.D. Injuries of Joints, by Edward Anderson, M.D., LL.D.

Anatomy, Descriptive and Surgical.—By HENRY GRAY, F.R.S., F.R.C.S., &c., with an Introduction on General Anatomy and Development, by T. HOLMES, M.A., Cantab., Surgeon to St. George's Hospital. The drawings by H. V. CARTER, M.D., with additional drawings in later editions. Edited by T. PICKERING PICK, Examiner in Anatomy, Royal College of Surgeons of England. A new American from the tenth English edition, to which is added "Landmarks, Medical and Surgical," by LUTHER HOLDEN, F.R.C.S., with additions by WILLIAM W. KEEN, M.D. Philadelphia: Henry C. Lea's, Son & Co.; Montreal: Dawson Bros.

This still remains the great standard text-book of Anatomy. The present edition is, in many respects, an improvement upon its predecessors. The added text and new drawings are decidedly advantageous, and add still more to that which, even without them, seemed to be well-nigh complete. Luther Holden's

"Landmarks" have been since their publication well received as a practical aid to the study of Medical and Surgical Anatomy. Their introduction here, along with "Gray's Anatomy" proper, does not increase the size of the volume beyond reasonable limits, and yet presents it in a place where it most appropriately belongs.

Books and Pamphlets Received.

TYPHOID FEVER IN VICTORIA. By James W. Barrett, M.B., Ch. B. Section I. George Robertson, Melbourne.

ASIATIC CHOLERA: Being a Report on an Outbreak of Epidemic Cholera in 1876 at a camp near Murree in India. By Charles Moore Jessop, M.R.C.P. London: H. K. Lewis.

INDEX TO THE TRANSACTIONS OF THE AMERICAN MEDICAL ASSOCIATION. Vols. I.–XXXIII. Prepared by Wm. B. Atkinson, M.D. Philadelphia, W. Fell & Co.

ELEMENTS OF PRACTICAL MEDICINE. By Alfred H. Carter, M.D., London. Second edition. London: H. K. Lewis.

PRINCIPLES OF THEORETICAL CHEMISTRY: With special reference to the Constitution of Chemical Compounds. By Ira Bemsen, Professor of Chemistry, Johns-Hopkins University. Second edition, thoroughly revised and enlarged. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Brothers.

SURGICAL APPLIED ANATOMY. By Frederick Treves, F.R.C.S. Illustrated with 61 engravings. Philadelphia: Henry C. Lea's Son & Co. Montreal. Dawson Bros.

ELEMENTS OF SURGICAL PATHOLOGY. By Augustus J. Pepper, M.S., M.B., Lond., F.R.C.S., Eng. Illustrated with 81 engravings. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Bros.

EPITOME OF SKIN DISEASES, WITH FORMULÆ, FOR STUDENTS AND PRACTITIONERS. By the late Tilbury Fox, M.D., F.R.C.P., and T. Colcott Fox, M.B., M.R.C.P. Third American edition, revised and with additions by T. Colcott Fox, B.A., M.B. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Brothers.

A TREATISE ON BRIGHT'S DISEASE OF THE KIDNEYS: Its Pathology, Diagnosis and Treatment. With chapters on the Anatomy of the Kidney, Albuminuria, and the Urinary Secretion. By H. B. Millard, M.D., A.M. With numerous original illustrations. New York: Wm. Wood & Co.

THE MEDICAL RECORD VISITING LIST, OR PHYSICIAN'S DIARY FOR 1884. New York: Wm. Wood & Co.

A TREATISE ON SYPHILIS IN NEW-BORN CHILDREN AND INFANTS AT THE BREAST. By P. Diday. Translated by G. Whittley, M.D. With notes and an appendix by F. R. Sturgis, M.D. New York: Wm. Wood & Co.

CLINICAL CHEMISTRY. By Charles Henry Ralfe, M.A., M.D., Cantab. Philadelphia: Henry C. Lea's Son & Co.

THE DISSECTOR'S MANUAL. By W. Bruce-Clarke, M.A., M.B., F.R.C.S., Eng., and Charles Barrett Lockwood, F.R.C.S. Philadelphia: Henry C. Lea's Son & Co.

ON THE PATHOLOGY AND TREATMENT OF GONORRHŒA. By J. L. Milton. Fifth edition. London: Henry Renshaw.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, Nov. 23rd, 1883.

T. A. RODGER, M.D., PRESIDENT, IN THE CHAIR

Uterine Fibroid.—DR. GARDNER exhibited a number of fragments, making up a fibrous polypus he had removed from the uterus of a patient sent to him by Prof. Geo. Ross. The patient, aged 48, unmarried, presented no evidence of ever having been pregnant, is very fat, and very anæmic. Gave a history of frequent hemorrhages and watery discharge for a few years, with little or no pelvic pain. On examination, the ostium vaginæ was narrow and rigid; vagina distended to the extent of the pelvic cavity by a tumor of very firm, somewhat elastic, consistence, and uneven surface, about the size of a child's head. The tumor could be partially rotated. Diagnosis from inversion could not be made by the sound, as it could not be passed around the tumor. Under ether, the fundus uteri could be indistinctly outlined through the thick abdominal wall. After incision of the perineum and orifice of the vagina, a running noose of strong twine was slipped over the tumor and drawn tight around the pedicle. A vulsellum forceps was then fixed on the tumor, and successive portions removed until at last a large portion—the residue of the growth—came away in the forceps. Very little blood was lost during the operation. The pedicle was found to be attached to the anterior wall of the uterus, above the internal os. It was trimmed off, and touched with Churchill's tincture of iodine. The uterus measured three inches in depth. The vagina was tamponed with alum cotton with iodoform—not because of actual hemorrhage, but as a precautionary measure. The patient recovered without a bad symptom. There was no pain worth mentioning, and the temperature never rose above 99.5°F. Microscopic sections made by Dr. Wilkins shewed it to be mainly fibrous in structure. In parts, smooth muscle fibres were to be seen.

DR. TRENHOLME said that the diagnosis of a polypoid tumor occupying the vagina is usually not very difficult to make out.

The mobility of the tumor in this case, and the absence of vesical complication, together with the solid character of the growth, rendered it specially easy to diagnose. As to treatment, he (Dr. T.) had seen a case some time ago where the lady declined any operation, and in which he had simply twisted the tumor round a couple of times, and this cut off its blood supply. A short time afterwards the growth came away by sloughing, and the patient made a perfect recovery. In this case a similar mode of treatment would have been most likely followed with the same success without any operation whatever.

DR. GEO. ROSS said this case ought to be a warning against treating menorrhagia without making an examination. This patient was blanched and weak, and had been treated by several physicians, who never had made any examination of the pelvic organs.

DR. GARDNER also shewed the *Uterus* of a woman aged 60, who died last August. The patient, referred by Dr. Roddick, was first seen at the University Dispensary for Women on 30th January last. Unmarried; no signs of pregnancy. Menses ceased seven years ago. Health always good until a year ago. At that time she had a bloody discharge from the vagina, lasting a week; six months later a similar discharge, lasting three days; three months afterwards a recurrence of the discharge, which has continued to a slight extent ever since. It is pale, and free from clots. Intermittent hypogastric pain prevailed. On examination, abdomen flaccid, a few lineæ albicantes; cutaneous aspect of perineum slightly lacerated; vagina very narrow and atrophied, slight pale bloody discharge escaping. Bimanual examination reveals distinct enlargement and decided firmness of uterus; it is mobile. Cervix small, admitting with difficulty an Emmet's silver probe the size of an ordinary surgical probe; this entered four inches, causing free bleeding. The diagnosis then made was intra-uterine malignant growth. A month later patient returned for treatment. She was put to bed. The os was incised bilaterally, as no laminaria tent fine enough for introduction could be got. Successive tents were then introduced, until the finger could be inserted within the uterine cavity. A soft, easily broken down growth was at once detected. The sharp curette

was used freely, and a large quantity of brain-like substance removed. Hemorrhage was free, but soon arrested by Churchill's solution of iodine and plugging. The result was undoubted but temporary relief. After the pain and slight fever following the operation had subsided, symptoms returned, and in about two months later, after labor-like pains for a few days, a portion of the recurrent growth was found projecting through the now dilated orifice. The curette being again used, a much larger quantity of the same substance than at the first operation was removed. Decided, but temporary, relief again followed. After this she lived four months, suffering much from pain, fetid, but not bloody, discharge, diarrhœa, rigors, high fever and perspiration. Death took place from exhaustion. At the autopsy, made by Dr. Osler, the uterus is described as being enlarged eight times its normal size; it fluctuates, and is soft. Examined from the vaginal os, it presents a ragged, sloughy-looking mass projecting from the upper and left side. On section, the entire inner surface is involved in an extensive sarcomatous growth which has sloughed on the surface, and presents dark shreddy, soft, disintegrating portions. The margin of the os is free, with the exception of one spot, at which the portion already noted projects. In places the growth is an inch thick. At one spot of the posterior wall the growth has perforated. Ovaries and broad ligaments unaffected. A secondary deposit was found on one pleura. During life, an elevated spot the size of a ten-cent piece existed on the anterior vaginal wall; this had the same histological character as the growth in the uterus. Microscopic sections of the substance removed from the uterus during life showed the structure to be numerous small, round cells, with very scanty stroma.

DR. GARDNER said that in some quarters the treatment adopted might be considered as open to criticism. The most favorable cases for extirpation of the uterus were those of sarcoma. Freund's operation by abdominal section he considered absolutely unjustifiable. If the uterus is ever to be extirpated, it should be done by the vagina, after Schröder's method. The great size of the uterus, and the narrow vagina, rendered the case unfavorable

even for this method. He quite agreed with Dr. Reeves Jackson of Chicago in the views he put forth at the meeting in September of the American Gynecological Society in Philadelphia. Dr. Jackson believed that extirpation of the uterus, instead of saving life, had destroyed many years of life.

DR. TRENHOLME remarked that if ever we were warranted in extirpation of the uterus, this was such a case. The uterus, though large, was free, and could readily have been brought down and removed. However, the fact of Dr. Osler finding secondary cancer deposits in the lungs shows that perhaps it was as well not to have attempted it. The smallness of the vagina, in his (Dr. T.'s) opinion, did not preclude the operation if otherwise desirable. In cases of midwifery, cases are now and again reported where the whole vagina has been torn up to Douglass's fossa, and yet the patients made good recoveries. Where necessary, we could divide the vagina and complete the operation.

DR. OSLER exhibited *a heart showing ulcerative endocarditis*, and remarked that we have had exhibited at our Society the two kinds—one, quickly fatal, with typhoid symptoms; the other, more chronic. The case was diagnosed ulcerative endocarditis by Dr. Wilkins. The patient had also acute pneumonia. The heart showed old sclerotic valves with deposit of lime salts. One of the chordæ tendineæ was ulcerated across. The cavities were dilated, and the left side hypertrophied. The spleen was also enlarged, and had numerous infarcts through it.

Case of Puerperal Eclampsia.—DR A. L. SMITH read a paper on this case. He saw his patient about the seventh month, who complained of pains in her head, back, and lower part of abdomen; said she felt silly, and saw things upside down. Micturition painful and frequent, but urine scanty in amount, high colored, and loaded with albumen. Feet and eyelids swollen. A few hours later, was sent for, as she had taken a fit. Used a mixture of alcohol, chloroform and ether as an anæsthetic; this arrested the clonic spasms, but unconsciousness remained, broken only by recurring seizures till evening, when a consultation with a senior *confrère* was sought, and twenty leeches to the temples

recommended. As the last leech fell off, consciousness returned, and she steadily regained her usual health. She was kept in bed on a strictly milk diet for several weeks, during which time the albumen decreased rapidly. Four weeks later Dr. Smith delivered her of a dead fœtus, much decomposed. She made a perfect recovery. Dr. Smith lays his success to the bleeding and rigorous milk diet, as recommended by Dr. Donkin, whom he quoted at some length.

DR. GARDNER said that the efficacy of hypodermic injections of morphia or Liq. Battley was extraordinary in these cases. He had used it frequently with very satisfactory results, even where convulsions came on weeks before labor.

DR. ROSS said the question of bleeding was divided. His own experience went against it. Only once saw good results follow, and that time the patient was a small, weak woman. He had several times seen strong plethoric women bled without any benefit. Has found chloral, given early, very useful, but morphia more reliable, and recommended hot air baths.

DR. TRENHOLME said the pulse was a good indicator to bleed or not. If strong and bounding in a full-blooded person, believed bleeding to be the best treatment. If convulsions came on some time before full time, then an opiate would be good. If at full time, and os dilatable, give chloroform and deliver. He agreed with Dr. Smith's treatment of his case as regards the form of bleeding and milk diet.

DR. GARDNER spoke highly of hot air baths in these cases.

DR. RODGER said he had treated a good many cases of puerperal convulsions. Used to bleed if the person was strong, but of late, in all cases, uses hypodermics of morphia. Chloroform or ether have not given satisfaction, nor has he seen the good effects from chloral and bromide of potassium which others speak of. Some time ago had a patient six months pregnant, with 75 per cent. of albumen in her urine, who had a convulsion. He gave her a hypodermic of half a grain of morphia, repeating it in six hours. She had no more seizures till three weeks after. Again he used the morphia, which stopped them for two weeks more, when pains came on, and she was delivered of a dead fœtus.

Stated Meeting, Dec. 14th, 1883.

DR. RODGER, PRESIDENT, IN THE CHAIR.

Syphilitic Caries of inner table of skull.—Great thickening of Calvaria—Compression and Deformity of Brain.—Dr. OSLER exhibited the skull-cap and brain—The patient, a woman aged 35, had been in hospital many times during last six years with various symptoms of constitutional syphilis. Was not under regular constitutional treatment in the intervals. At one time had necrosis of right tibia. In November, 1882, was admitted with a small open sore in right parietal bone through which dead bone could be felt, and a probe passed far in between the bare bone and dura mater, towards the vertex. Symptoms chiefly debility and severe right unilateral headaches. Was in hospital several times within last year, and amyloid disease of kidney was made out. During her last illness, as on the previous occasions, her intellect was clear, and although within a few days of her death she was dull and very irritable, it was probably due to the severe pains in her head and her increasing weakness. Never had any signs of local brain disease. The headaches were very severe at night. The external surface of the skull cap was smooth, and on the right side, close to the coronal suture, was a small sinus through which a Bowman's probe could be passed. On removing the calvaria, which was moderately thickened in the supraorbital regions, a quantity of thick pus escaped. The dura mater was thickened and strongly adherent posteriorly. The internal surface was smooth and did not present any adhesions. As shewn in the specimen, the disease is confined to the contiguous surfaces of skull and dura over the frontal and part of the parietal regions. The inner aspect of the bone in these parts is rough and carious, having an eroded, worm-eaten appearance, and covered with granulations; and towards the parietal bone, firm, solid, fibrous masses unite it to the dura. The upper half of the frontal and the greater part of the parietal bones are thickened, measuring from two to three centimetres, and are exceedingly dense. The outer surface of the dura-mater shews numerous soft granulations springing from

solid fibrous tissue. The falx in its anterior half is thickened, and the longitudinal sinus is in this part obliterated. The brain shewed no trace of coarse disease; the arachnoid was a little opaque, but the pia-mater was normal. The hemispheres were curiously deformed from the pressure to which they had been subjected by the thickened bone and dura, and the pus between them. They are wedge-shaped, the base is at the occipital bones, where the greatest vertical height is eight centimetres, and the apex is at the orbital magin of the frontal lobes, where the height only two-and-a-half centimetres. This curious deformity has been brought about slowly, and illustrates the degree of pressure to which the brain may be subjected, so long as it is applied gradually.

DR. HENRY HOWARD referred to the remarkable absence of cerebral symptoms in such extreme compression.

DR. OSLER also exhibited a skull from the museum of McGill College, with syphilitic destruction of the entire right parietal and part of the frontal bones, with caries also of the inner table.

Epithelioma of Tongue—Excision—Erysipelas—Circumscribed Gangrene of Lung—Perforation of branch of Pulmonary Artery.—DR. SHEPHERD narrated the case and showed the specimen: Thos. W., aged 42, a strong, healthy man, came to the Montreal General Hospital in January, 1883, suffering from epithelioma of the tongue; this being near the tip, only a portion of the tongue (right half) was removed with the scissors by Dr. Fenwick. Two months ago he noticed that the growth was returning, and at the time of his re-admission into hospital, under Dr. Shepherd, early in November, it was increasing rapidly. He then had an epitheliomatous ulceration of the part of the tongue that remained, and also of the right tonsil and left anterior pillar of fauces; the floor of the mouth was infiltrated and hard. It was decided to remove the whole tongue. This was done on November 10th. Dr. Shepherd first ligatured the lingual artery of each side by a curved incision reaching from the front of the angle of the jaw to the hyoid bone, and up towards the symphysis. After ligaturing the linguals, the tongue was removed by scissors with very little trouble and no hemorrhage, after Mr. White-

head's method. The right tonsil (or part of it) and the anterior pillar of fauces were removed also by scissors. After the operation the patient rallied well, and was fed for two days by nutrient enemata, the mouth being rinsed out frequently with a solution of Condy's fluid. For five days the man did well; there was no fetor from the mouth, the wound was granulating nicely, and the incisions made for tying the lingual were healing by first intention, when, on Nov. 15th, erysipelas appeared on the nose and rapidly spread over face, neck and head. Temperature rose to 103°–104°, and pulse became rapid (120) and weak. The erysipelas then spread over the chest, and the mouth now became sloughy; fetid breath was first noticed on Nov. 27th, at which time a slight cough developed, and some bronchitis, which was looked upon as septic. No rigors or sweatings had occurred. From this time patient became gradually weaker and weaker, in spite of the stimulating treatment, and died suddenly on December 2nd from hæmorrhage. Dr. Shepherd remarked that at the time of the operation several cases of erysipelas had been admitted into the hospital from outside. With regard to the operation, he felt perfectly satisfied with it, the previous ligaturing of the linguals greatly facilitating the removal of the tongue by scissors, as all fear of hemorrhage was removed, and the scissors left a clean, instead of a bruised, surface, as is seen after the use of the écraseur. The method of operating had nothing whatever to do with the fatal result.

At the autopsy the wound looked in process of healing, and the cancerous masses had been removed. The linguals presented thrombi at the site of ligature. There was a small pocket of pus beneath the left sterno-mastoid. The trachea and bronchi were filled with blood. The right lung presented four areas of circumscribed gangrene, the left two, each about the size of small apples. Placing the lung under water and blowing water through the pulmonary artery, bubbles escaped from one of the gangrenous regions close to the root of the lung. Dissection proved, as the specimen shows, that the hemorrhage came from a small branch of one of the main divisions of the artery, which had been opened in the necrotic process.

DR. R. P. HOWARD spoke of the frequency with which gangrene of the lungs followed operations on the tongue and neck.

DR. GEO. ROSS mentioned having had a case of Cancer of the œsophagus in Hospital last winter which proved fatal from gangrene of the lung.

Sarcoma of Lumbar Glands; Perforation of the Colon; Persistent Hemorrhage.—DR. SHEPHERD presented the specimen and gave the following notes: Man, aged forty-five, large, strongly built, weighing over two hundred and fifty pounds, sent for him on July 23rd, and stated that he had been seized in the night with severe pain in the back and abdomen. The temperature was 103°, pulse, 120; tongue coated; great tenderness of abdomen, with fulness in left iliac region; no vomiting; bowels had been opened several times during the night. In the evening he was worse. Temperature, 104°; pulse, 120; great abdominal distension with tenderness. On the 25th the temperature was normal, but the abdominal symptoms persisted, and there were diarrhœa and frequent vomitting. On the 29th he had a severe rigor, with temperature of 104°, and profuse sweating; tympanites and pain, with evidences of peritonitis. In a day or two he had another rigor, with severe vomiting and diarrhœa, and great abdominal distention. Dr. Ross saw the patient in consultation, and the conclusion arrived at was, that there was local suppuration deep in the iliac region. His condition at this time was very bad; pulse weak; vomiting incessant. With champagne and careful feeding the vomiting was checked, and he began to improve slowly, until in the early part of September he was able to move about the room. There was still fulness on deep pressure in the iliac fossa, but the thick layer of fat prevented a satisfactory examination.

About September 10th he began to pass a small quantity of blood—bright red—with the stools, and this increased until the daily amount was often as much as half a pint, and he became very anæmic. In the month of October he again took to bed; had severe rigors with high temperature and sweats, about every other day. At this time a tumor was made out in the hypogastric region, deep in the abdomen, fixed, solid, and not

tender on pressure. Rectal examination negative. The loss of blood continued, and he got much weaker, and death took place on November 20th, after a profuse hemorrhage. The tumor had increased in size, and a week before death it seemed about the size of a child's head, and firmly fixed in the hypogastric region. The autopsy showed matting together of the coils of intestine with old peritoneal adhesions, particularly near the pelvis. The tumor was in front and a little to the left of the lumbar spine, and the sigmoid flexure was firmly united to it. The mass was readily turned out, and dissection revealed an extensive perforation of the bowel, as the specimen shows, and exposure of soft sloughing masses of the tumor. The wall of the colon was defective in an area two and a half by one and a half inches. The growth was a sarcoma of the retroperitoneal lymph glands. There were no secondary tumors, and nothing of note in the viscera. The persistent hemorrhage for over two months, had evidently come from the vessels of the exposed and sloughing part of the tumor. The repeated rigors were difficult of explanation; there evidently had been peritonitis, but whether local suppuration had occurred was not so clear, possibly it had in the process of perforation of the bowel.

DR. GEO. ROSS remarked that he had seen the case several times, and it had offered considerable difficulty in the way of diagnosis. The amount of abdominal fat prevented a satisfactory examination, and the fulness in the iliac region was thought to be possibly a focus of suppuration. Later on, when the hemorrhage occurred, and a more evident tumor could be felt, the diagnosis was made of malignant growth, and from the situation and size, probably retroperitoneal and involving the bowel.

DR. HOWARD said that from the same symptoms he would have diagnosed as did Drs. Shepherd and Ross. He congratulated them on having located the tumor so exactly.

Small Tumor on Nerve: Intense Brachial Neuralgia; Removal.—DR. SHEPHERD presented a microscopic section of a small tumor the size of a bean, which he had removed from a man's arm for painful neuralgia. The patient, a thin, nervous man, stoker by occupation, was admitted to hospital complaining

of severe pain in the left arm—so bad that he could get but little rest at night. His appearance was that of a man suffering intensely. The pain was more severe at times, and was situated at the insertion of the deltoid, and from there ran down the back of the arm to the elbow. He also had numbness along the ulnar nerve. Just below the posterior fold of the axilla, internal to the brachial artery, a small nodule the size of a bean was felt, which on pressure caused agonizing pain. Dr. Bell admitted the case as one of neuroma. Dr. Shepherd had removed the growth, which was found connected with a small nerve, and closely united with the cellular tissue at the back of the artery. The man has had no pain since the removal, three days ago. The section of the tumor showed a fibrous capsule, and a small, angular-celled growth inside.

A report on the nature of the tumor was requested for the next meeting.

Early Symptoms of Tabes dorsalis.—DR. STEWART exhibited a man, aged 33, clerk, whose only complaint was of dimness of vision. He first noticed failure of his sight ten weeks ago. Three weeks after, he consulted Dr. Buller, who diagnosed the case as one of Tabes dorsalis. Twelve years ago he saw double for a week. In the year 1879, he recollects seeing double for about three days. With the exception of these two occasions, and a few days during which he was sick from measles, he has always enjoyed excellent health. He never had syphilis. The family history is unimportant. Three years ago he worked for several months in a very damp cellar.

Present state:—There is permanent contraction of the right pupil (myosis). There is loss of reflex contraction of the pupil (Argyll Robertson symptom). Both pupils readily contract on accommodation. In addition to the loss of reflex contraction, he has also undoubted loss of reflex dilatation of the pupils. There is well marked atrophy of both discs. The patellar reflex is absent in both legs. This is the only symptom characteristic of Tabes dorsalis present, with the exception of the eye symptoms. There are no lightning pains, no paresis of the bladder or rectum, no ataxia, no delayed, lost or perverted sensations.

The skin reflexes are present. Notwithstanding the absence of some of the prominent symptoms, there can be no doubt whatever about the nature of the case. It is an undoubted case of Tabes dorsalis in its pre-ataxic stage. The case is a good example of what is now generally conceded, viz., that Tabes dorsalis is essentially a disease of the sensory tracts. Three of the most prominent symptoms are failure of the normal reflexes. There is (1) loss of the reflex contraction of the pupils; (2) loss of reflex dilatation of the pupils; (3) loss of the patellar reflexes.

Treatment.—During the last seven weeks the patient has been treated with the *faradic brush* three times weekly, after the manner recommended by Rumpf of Bonn.

In reply to questions asked by members, Dr. Stewart said that his patient probably contracted the disease while working in the damp cellar three years ago. The patient was slightly worse now than when he commenced the faradic brush treatment.

Dr. BULLER here remarked that one eye was a little better, the other rather worse, than when first seen. The patient consulted him on account of failing vision. He found his sight much impaired. R. E. V., 20/100; L. E., 20/70, with great concentric limitation of the visual fields. The field for colors was constricted in a similar manner, but there was no central scotoma. The optic nerves presented the usual appearance of progressive atrophy from spinal sclerosis. The condition of the eyes, together with the absence of patellar reflex, seemed to warrant the diagnosis of *Locomotor Ataxia.*

DR. OSLER asked if the very early symptoms were preataxic, as it was well known that the eye symptoms often preceded for a long time lightning pains, etc.

DR. R. P. HOWARD said that one of the first cases diagnosed in Montreal was one of his patients, who came to him suffering with transient strabismus, his walk was slightly axatic, but there were then no pains, he lived 15 or 16 years, and died in Europe last year. He had myosis.

DR. HENRY HOWARD remarked that he has had several cases under observation where impotency was the first symptom.

DR. OSLER, the past summer, had a patient under his care who had been troubled with double vision, and severe headache for four or five years. He went to London and consulted Dr. Broadbent, who diagnosed and treated him for cerebral syphilis. He got perfectly well, but two years ago Tabes began to develop, and now he is in the third stage of Locomotor Ataxia.

DR. ROSS said a patient came under his care yesterday in the Hospital, who had had the gait symptoms for two years, but till lately had had no eye symptoms at all. At present he is remarkably ataxic, has loss of patellar reflex, no lightning pains. Dr. Ross had asked Dr. Buller to examine this patient.

DR. BULLER remarked that the hospital patient with ataxic symptoms, sent to him by Dr. Ross for examination yesterday, had no loss of vision. His optic nerves, however, did not present a healthy appearance. They were somewhat swollen, and the margins decidedly indistinct, perhaps presenting the condition described by Dr. Gowers as gelatinous infiltration. The bulk of the papilla had a hyperæmic appearance, whilst the temporal side was in part rather unusually pale. On the whole, I think the condition was such as we usually meet with in persons whose vision is beginning to suffer from excessive use of tobacco and alcohol. With regard to the atrophy of the optic nerves met with in Locomotor Ataxia, Dr. Gowers has made the observation that when this condition comes on early in the course of the disease, that is, during the first or pre-ataxic stage, the resulting loss of vision is more rapid and more complete than when occuring as a later symptom; this observation coincides with my own experience of such cases. When atrophy of the optic nerve occurs early it must, I think, often be a matter of doubt as to whether the trouble is of spinal origin at all. I know of several cases in which atrophy of the nerves has led to complete blindness, which has now lasted for one, two, or three years without the development of any fresh spinal symptoms, though there has all along been absence of knee-jerk, yet all of these cases have been regarded as commencing Locomotor Ataxia by the very highest authorities on the subject, both in Europe and America.

DR. R. P. HOWARD said he had three cases of Locomotor

Ataxia at present. In two, there is great contraction of the pupils—one a gentleman, the other a lady. The gentleman has myosis of both eyes, but greater in one. In the third case the pupils differ, there is good vision in one eye. Dr. Howard remarked that a contracted pupil should make one look out for Tabes. There is great frequency of pulse in one gentleman and in the lady. The gentleman took Hyosciamin for a long time under Dr. Seguin, with but little effect. Dr. Howard said a late theory was that this disease was caused by functional excess of a sensory nerve, and that sexual excess was said to lead to it. Dr. Howard also remarked that out of many cases which he has seen, one only suffered from gastric crisis. Had used the electric brush in the case of the lady with the result of restoring feeling in some parts of the skin, otherwise no improvement followed.

DR. HENRY HOWARD had used the electric brush for anæsthesia with good effect where there was absence of motor paralysis.

Lawson Tait's Operation.—DR. ARMSTRONG exhibited the ovaries and tubes removed by him a couple of days previous from a lady, aged 22, who had suffered for three years from pelvic pain. She had menstruation for fourteen days for the past year, suffering much each time; this quite unfitted her for work, and made life miserable. Both ovaries were prolapsed. Patient doing well. The ovaries were both a good deal enlarged.

OTTAWA MEDICO-CHIRURGICAL SOCIETY.

The regular meeting of this Society was held on Friday, the 30th of November. Present: Dr. Robillard, President; and Drs. J. A. Grant, H. P. Wright, S. Wright, Prevost, Horsey, Powell, Grant, Jr., Malloch and Small.

Dr. Playter was introduced by the President, and unanimously elected a member.

DR. PREVOST communicated the results of some experiments with "*Jequirity*," a new drug recommended for the treatment of granular lid, exhibiting some samples of the drug. It is especially indicated in cases of trachoma, where pannus is a marked symptom. Eight beans are placed in 4 ozs. of cold water, and 4 ozs. hot water added. The granulations are painted

with the solution, and the patient told to wash the lids every day, allowing a small amount to penetrate beneath the lids. It acts as an irritant, causing œdema and purulent discharge in some cases. When these acute symptoms subside, the eye is found to be free from the troublesome disease. He had used it in several cases with success; so had Dr. Robillard.

DR. POWELL read a paper on "*Typhoid Fever: its Complications and Sequelæ.*"

A vote of thanks was accorded the reader, who was complimented upon the thoroughness and originality displayed in its preparation.

The discussion that followed was confined to "high temperature."

DR. H. P. WRIGHT agreed with Dr. Powell that a continuous moderately high temperature was more serious than a temperature very high, but of short duration. He cited cases in point that had terminated fatally.

DR. POWELL believed baths would prove of service in such cases, on account of their effect on the nervous system.

DR. PREVOST had frequently taken the temperature of patients before and after sponging, without detecting any decrease of temperature. Believed that too much attention was given to treating the symptoms; if the fever was properly treated on general principles, the temperature would soon moderate.

DR. MALLOCH said the use of febrifuges had always proved very unsatisfactory in lowering temperature. Had no faith in quinine, as its action was of very short duration.

DR. S. WRIGHT, in all his cases, gave 5-grain doses of quinine every three hours, and has always kept the temperature down to 100° or 101°. Some patients cannot bear the drug. In the patients where head symptoms follow, a lessening of the dose overcame the difficulty. He reported a case where 40 grains had been given daily for three weeks. During the first week only had cerebral effects been noticed.

The discussion of the other complications was adjourned to the next meeting.

DR. GRANT, Jr., exhibited *a Brain* containing a small solid tumor pressing on the upper portion of the ascending frontal convolution on the right side. A report of the case was promised for a future meeting.

Extracts from British and Foreign Journals.

Unless otherwise stated the translations are made specially for this Journal.

The Prevention and Treatment of Chilblains.—I doubt whether it can be correctly said that chilblains are local congestions. With the exception of the very mildest and slightest cases, if even these can be excepted, there has always seemed to me to be something more than congestion. The classical signs of inflammation, *rubor et tumor, cum calore et dolore*, are all present; indeed, a chilblain, in its first or so-called erythematous stage, presents a remarkably good illustration of a simple dermatitis. If neglected at this period, a blain rather rapidly forms, and, under the slightest friction, quickly gives place to a very tender superficial ulcer; this ulcer is surrounded by skin which is acutely inflamed and tender. It is this combination of a superficial and very vascular ulcer, with extensive underlying and surrounding inflammation of the skin, which is most characteristic of the later stage of chilblain. The gentlest touch on the diseased finger gives pain; and the dread excited by the fear of a blow or rough handling may render the sufferer so miserably nervous, as to lead him to seek to escape from games and outdoor amusements, and so to avoid the means best tending towards prevention. Boys are very merciless to each other; and I believe the best and quickest treatment, when a case has reached such a stage, is to put the boy on the sick-list for a day or two, and apply continuous poultices until the surrounding inflammation has gone down, and we have to deal only with the ulcer, which will quickly heal under favourable conditions. Occasionally, beneath the blain, or even before it has appeared, a limited sphacelus, involving the whole thickness of the true skin, occurs; after this becomes detached, a deep ulcer, with sharply cut edges, is left, but without any marked amount of surrounding inflammation. This ulcer is much less painful than the condition above referred to, and heals slowly, but without any difficulty, though it leaves, of course, an ugly scar. It is the first or so-called erythematous stage that is most amenable to treatment. My experience quite agrees with the

statement that counter-irritants are no good. An exception might, perhaps, be made with regard to iodine, which seems to act, however, more as an astringent, and perhaps, by hardening the outer layers of the epidermis, may cause some pressure on the deeper layers of the cutis. Collodion is worse than useless; after drying, or even in the process of drying, it splits and cracks in various directions, and in each crack in the collodion a crack in the skin is liable to occur. Careful packing with cotton-wool, is the most trustworthy treatment. A little calamine lotion, applied first, and allowed to dry, will help to allay the distressing itching.

It may be remarked that chilblains are especially apt to occur when the weather is both damp and cold. As a boy, I have often gone through a fortnight's frost with no chilblains, or the very slightest; whereas, as soon as the thaw has set in, my hands have at once become covered with numerous chilblains. The explanation of this is to be found in the fact that, in a thaw, the air is heavily charged with moisture, so that it is impossible to keep either boots or gloves dry, and the bared hand must be always moist. The evaporation which, under these conditions, is always going on, must necessarily keep the temperature of the parts continuously, for extended periods, below the normal. My experience is that, probably for the same reason, it is a mistake to wash the hands in tepid water; and warm water is not to be recommended. I was early led by my own sensations to prefer very hot water. To plunge the hands in hot water, and then to raise the temperature still further by the addition of fresh quantities of still hotter water, certainly allays the irritation, diminishes the size of already existing chilblains, and, I believe, also aids in preventing the occurrence of fresh ones. The action of "hot water" is, as its recent use as a hæmostatic has proved, essentially different from the action of "warm water." Further, I believe that the use of "hot water" for washing the hands is beneficial, because they can be dried more rapidly and surely than when tepid or warm water has been used. In the case of children subject to chilblains, I should, therefore recommend woollen stockings and armlets (reaching to the axilla); the use

of very hot water for washing hands and feet, and rapid drying with a dry absorbent towel; and, finally, the exercise of the greatest care in seeing that boots and gloves are dried before use. To dry the boots, whether apparently wet or not, the soles should be exposed to the fire, and cautiously approached to it until thoroughly warmed through. The constitutional condition which underlies the pathology of chilblains is, no doubt, benefited by the use of tonic remedies, such as iron-phospate; but not, I believe, by cod-liver oil or high feeding.—*Dr. Dawson Williams, in British Medical Journal.*

Rapid Absorption of a Pleuritic Effusion by Treatment with Common Salt, and Cutting off Liquids.—John C. came under my observation on August 1st, 1882. He was then suffering from a well-marked pleurisy, *i.e.*, pain, catching breathing, and a cry at the end of inspiration. He sat up in bed and held his hand against his side, complaining bitterly of the pain. A bandage was put firmly round the thorax, with much and rapid relief, and he was ordered absolute rest, a liquid diet, and some opium. On August 2nd he was evidently much relieved, and his respiration was more uniform, deeper and attended with less pain. On August 3rd I was hastily sent for, and, on my arrival, I found my patient in great and urgent distress. His lips were livid, his nostrils were smoky, his eyes were prominent, and his nails blue. He had cold clamminess of hands and brow, and he was breathing fifty-one times in a minute. The pulse was barely appreciable at his wrist. The heart was pushed over to the right. I told him of his great danger, and urged him to permit me to draw off the fluid. This he flatly refused to allow me to do, saying that a friend of his was tapped, and died one hour afterwards. This was at 11 a.m. I put him under the following conditions. He was to take every hour one tea-spoonful of common salt, dissolved in a wine-glassful of tepid water. I produced sweating by a hot wet flannel and a piece of waterproof sheeting, and I gave him two ounces of the common black draught at once, and stopped all fluids. At 1 p.m. he said: "I can get my wind now," and he had most markedly improved in every way. He looked less

livid. His respiration had dropped down to 48. At 9 p.m. he looked cheerful. The lividity had almost disappeared. He could lie on either side, and get well down in the bed.

On August 4th, on entering the room, I could not have detected any embarrassment of breathing, and all his subjective symptoms had disappeared. There was comparative dulness of the left base, but the air could be heard entering the lung. I now gave one drachm of common salt twice a day, and two ounces of the brandy-mixture of the *Pharmacopœia* every four hours, together with some oysters, an anchovy and Digby chick, or a piece of salted bacon. He did not complain much of the thirst, said his "mouth was dry," and his tongue looked red and glazed. From this time there is practically nothing to say, my patient never had a return of his symptoms, and he was up and out of doors in a week. It is barely necessary to comment upon the *rationale* of the treatment adopted in this case, and my only object in bringing it forward is to see whether like results will follow in the experience of other similar cases, or in any effusion which takes place into a serous cavity. The salt, I believe, increased the density of the blood; the blood became thirsty, if I may so express it, and drank up the pleuritic effusion in a manner to me singularly rapid and striking. Doubtless the sweating and purging aided me very much; but purging and sweating will not remove serous effusions with precision.—*Dr. Robinson, in British Medical Journal.*

Carbolic Acid as a Local Anæsthetic and Mouth-Wash.—Dr. Squibb says: Carbolic acid and other phenols with which it is associated are all very effective local anæsthetics, and this therapeutic relation is far too much overlooked or neglected. A paper by Dr. J. H. Bill, of the United States army, published in the *American Journ. of Med. Sciences* for 1870, page 573, first drew attention strongly to this point, and every one who has handled the acid much has amply confirmed Dr. Bill's experience, and yet the matter has been but imperfectly followed up. Even its application to the pain of burns, erysipelas, and other superficial affections, though often insisted upon, is not generally adopted, and when adopted

it is rarely in the best way. The writer knows from personal experience, and from extensive practice in his laboratory where burns and scalds are not unfrequent, that a solution containing from one-half to 1 per cent. applied by means of thin cloths, frequently renewed, will relieve the pain of burns within ten minutes; and the relief will be permanent if the application be continued during the twenty-four or forty-eight hours of primary irritation. Under such dressing the burns, if superficial, will not suppurate, and if deeper, the suppuration will be greatly diminished and modified. If the solution be applied too strong, it will at first increase the pain for a very short time; but the after-effects are less favourable, as the irritation of too much of the acid increases the tendency to suppuratien. A simple rule for guidance is that the renewal of the application should not cause smarting or renewal of the pain. The anæsthetic effect upon the acute suffering of burns and scalds is very remarkable. A 5 per cent. solution of the liquefied acid is a very convenient preparation to keep in readiness for making the more dilute solutions needed for burns, erysipelas, &c., and for such uses as protecting hypodermic solutions. One-twentieth of such a solution is quite sufficient to prevent the growth of micro-organisms in any preparation which needs protecting. It is simply to be added in making up the preparation to the required measure. A piece of paper moistened with a few drops of such a solution and kept in extract-pots, &c., will prevent the growth of mould. Such a solution diluted so as to be not stronger than 1 per cent., nor weaker than about one-half per cent., makes an excellent tooth and mouth wash for use in the morning. Habitually used, it in some degree checks the deposition of "tartar" on the teeth, keeps the tooth-brush sweet and clean, and there is nothing that leaves the mucous surfaces in so clean and pleasant a condition for the first meal of the day. A bottle of the 5 per cent. solution may be placed upon the washstand, and a couple of teaspoonfuls poured into the mug, diluted with four or five times as much water, stirred with the tooth-brush and then used upon the brush; the mouth being finally rinsed out with the remainder of the solution. This is a very good habit, which has

been followed by the writer and many others for many years with advantage. (*Ephemeris*, May, 1883.)

The Ill-doings of Flies.—Dr. B. Grassi, of Rovellasca, reports, in a recent number of the *Gazetta de gli Ospitalia*, some investigations he has been making on the above subject. He has convinced himself that the common house-fly is a dreadful enemy of the human race as of all living things in general. Wherever any infectious product is present, for instance, the sputa of phthisical patients, or dejecta from the intestinal tract, swarms of flies are to be seen, which soil themselves with the offensive material, and then crawl about over our food. The writer placed a plate containing a large mass of the ova of a human parasite (*Trichocephalus*) upon a table in his laboratory, which was situated at the distance of about thirty feet from the kitchen. Sheets of white paper were placed in various parts of the kitchen, and in the course of a few hours the dejecta of flies were observable on the paper. Upon examination of these with the microscope, they were found to contain some of the ova of the parasite. Dr. Grassi then killed some of the flies, and found an enormous mass of feces containing more of the ova. On another occasion he minced some segments of tape-worm that had been preserved in spirit, and put them into water, so that a mass of ovæ were suspended in it. In half an hour he succeeded in finding the ova of the parasite in the abdominal contents of the flies, and also in the spontaneously deposited dejecta. In like manner it could be proved that flies that had alighted on moldy cream harbored the spores of *oïdium lactis*. It is useless to comfort one's self with the thought that these germs die in the intestines of the flies. Even if the intestinal juice does act upon them, and it is not proved that it does in the case of bacteria, some would almost certainly escape destruction. In any case, moreover, the legs and proboscis would still serve as carriers of the infection. He proposes that attempts shall be made to introduce the same disease among them in the spring time that already causes such devastation in the autumn.

Removal of the Thyroid Gland.—Extirpation of the enlarged thyroid gland has been of late years frequently practised, and, on the whole, good results have been obtained, thanks chiefly to the antiseptic system of dressing. Amongst the more important recent writers on this subject may be mentioned Professor J. L. and Dr. A. Reverdin, who have published in the *Revue Médicale de la Suisse Romande* (1883, Nos. 4, 5, and 6) an account of twenty-two extirpations of goître performed by them on twenty-one patients, twelve of whom were women. These cases are interesting, not only on account of the good results obtained, but also, and chiefly perhaps, because Messrs. Reverdin were able to examine their patients several years after the operation, and then discovered certain remarkable alterations of the general health, which will be mentioned below, and which had, it seems, escaped the attention of other operators. The following is a brief account of Messrs. Reverdin's paper. The size of the tumors varied from that of a hen's egg to that of an adult's head. Most of the tumours were parenchymatous, with or without cysts, and occupied more or less exactly the middle line; one sent a prolongation downwards behind the sternum. In seventeen cases, total extirpation was performed; once an enucleation was done, while the remaining were cases of partial extirpation. Of the twenty-two operations, two only were followed by death, which was caused, in one case, by dyspnœa and convulsions, and, in the other, by lobular pneumonia. On an average, the patients remained only sixteen days in the hospital after the operation, and, in ten cases, union by first intention was obtained.

Amongst the accidents which may accompany or follow the operation, Messrs. Reverdin mention hemorrhage, which is best prevented by securing the thyroid arteries as soon as possible; secondary hæmorrhage occurred in two cases. Dyspnœa was sometimes present before the operation, and in several cases prevented the administration of chloroform. The same complication, and also dysphonia, aphonia, and dysphagia, were often noticed after the operation, but generally disappeared after a short time. In three cases, tonic convulsions of the upper

extremities appeared after the operation; in one of these cases (mentioned above), they were accompanied by a severe attack of suffocation, and soon followed by death. In five patients, three of whom were men, a remarkable alteration of the general health showed itself some months after the extirpation of the thyroid gland. There were at first weakness and coldness of the limbs, then loss of appetite, slowness of speech, diminution of the progressive anæmia, accompanied, in two cases, by a peculiar œdema, most marked in the face, and very analagous to that which occurs in myxœdema. These symptoms partially disappeared after about three years. They seem to show themselves only after total extirpation, and are produced, according to Messrs. Reverdin, by a lesion of vaso-motor nerves, and by a mucoid infiltration of certain tissues, in consquence of the removal of the thyroid gland. These serious consequences, which have a remarkable analogy with cretinism on the one hand, and myxœdema on the other, must be taken into consideration in the prognosis. Nevertheless, extirpation (or, if possible, enucleation) ought to be performod, according to Messrs. Reverdin, when there are symptoms of imminent danger, such as attacks of suffocation, and also in cases of retrosternal or rapidly growing goître, when the ordinary treatment has proved useless.—*British Medical Journal.*

The Conversion of Malignant Tumors into Innocent Growths.—Prof. V. Nussbaum, in a clinical lecture recently delivered in Munich (*Wien. Med. Zeit.*, June 3, 1883—*Boston Med. and Surg. Jour.*, Oct. 25th), expressed the belief that he had discovered a procedure for the positive cure of cancer by restraining the proliferation of the tissue elements of the disease. It appears to him that a total interruption of all peripheral sources of nutrition is the means best adapted to secure this result. He accomplishes this object by the use of the thermo-cautery, with which instrument a deep channel is made quite around the malignant growth, thus cutting off entirely the supply of blood and other nutritive fluids from the surrounding tissues. The small vessels which ascend into the tumor from the parts beneath are sufficient to preserve

its vitality, so that gangrene does not occur. He thinks the thermo-cautery far preferable to the ligature. and that it possesses many advantages over the knife. He regards the hot iron and the various chemical caustics worthy of more extensive employment in the domain of malignant growths than they have ever enjoyed. Prof. Nussbaum doubts not that this circumscribing a cancerous growth, thus cutting off every channel of peripheral nutrition, has a brilliant future, especially in those desperate cases in which death is imminent from hemorrhage. In his experience, this method of cutting off the peripheral blood supply has afforded such astonishing results that he recommends this procedure to the attention and practice of all those having occasion to treat a case adapted to its employment.

Curious Malposition of a Tooth.—In a recent number of the *Lancet*, Dr. Gopaul Chunder Roy relates the case of a Hindoo lad, aged 14 years, who presented himself for treatment at the Soree Charitable Dispensary, for what he considered to be a tumour growing within the nasal cavity. He noticed a foul smell in his breath abont four months before, attended with catarrh and sometimes a bloody discharge from the left nostril. For the previous two months the growth had been observed to occupy the left cavity, where it seemed to be attached to its wall at its upper part, its free end was looking downward in the shape of a truncated cone. Arrangements were made for plugging the posterior nares, in the event of uncontrollable hæmorrhage, the tumor was seized with dressing forceps and extracted. It proved to be a tooth of the shape of a canine. There was very little bleeding after extraction, and this was stopped by alum lotion. The free extremity was covered with enamel, which stopped short at its junction with the root. The root was deeply imbedded in the side and upper part of the antrum. The boy had got his set of permanent teeth, with the incisors and canines entire on either side. There was no deformity of the jaw and no swelling or cystic formation. It was clearly a case of extra-follicular development and eruption of a tooth in a wrong place, the peculiarity being that while in reported cases of like nature the crown of the tooth shows itself

at the floor of the nasal cavity from below upward, in the present instance, by some freak of nature, the dental follicle was transposed, and the eruption was from above downward. The tooth has been sent to the Royal College of Surgeons' Museum.

The Differential Diagnosis of Tic Douloureux and Dental Neuralgia.—Magitot, of Paris, some time ago expressed the opinion that these two varieties of prosopalgia were clearly distinguishable by their symptoms alone. Tic douloureux he would define as an affection of the cutaneous branches of the trigeminus, occurring in paroxysms of an intermittent and spasmodic character which are provoked by the slightest contact or movement; while neuralgia originating in the teeth is increased or diminished by forces acting upon the oral cavity, such as the pressure of foreign bodies, atmospheric air, heat, cold, certain drugs, etc., none of which exert any influence in the case of tic. This view is controverted by Dr. Th. Walzberg, in the *Centralblatt für Chirurgie* November 10, 1883. He maintains that there is nothing specially characteristic in the symptoms of either complaint, and proposes to divide the facial neuralgias into two classes, viz: those whose causes can, and those whose causes can not, be determined—the latter answering to the tic douloureux of Magitot. He adduces in confirmation three cases of prosopalgia successfully treated by himself. Concerning the first two of these he observes that they exhibit almost precisely the same assemblage of symptoms, yet that one of them certainly did not originate in the teeth, although presenting all the features characteristic of dental neuralgia, according to the French author. The third case, the symptoms of which would place it in Magitot's first class (tic douloureux)—and which also strongly resembled an intermittent disease—shows that a neuralgia may arise from the teeth, although entirely uninfluenced by agencies affecting the interior of the mouth. Symptoms in these complaints may facilitate the discovery of their causes, and so guide us to a successful plan of treatment, but only the most accurate objective examination in every case will protect effectually against error. It is better to search in vain for a tooth-root, upon the slightest suspicion,

than uselessly to divide a nerve. A remark is appended relating to the mode of performing this operation. When it is designed to follow up to any considerable extent the ramifications of the infraorbital nerve upon the cheek, it is better to make the entering (semicircular) incision at a point somewhat below the orbital wall; otherwise a pouch will be formed too small for separate drainage, but large enough to act as a reservoir for the secretions, with the result of setting up a suppuration which will much prolong the process of healing. The latter, under favorable circumstances, should not occupy over five days.

M. Pasteur on the Etiology of Cholera.—The Paris correspondent of the *Lancet* says: M. Pasteur having been solicited to lay before the public the instructions he had given the members of the scientific mission to Egypt to investigate the nature of cholera, now raging in that country, and which was noticed in your annotation of last week, has generously complied with the expressed desire of his friends. M. Pasteur prefaced his instructions (of which I send you an abstract copy) by remarking that the precautions hereinafter enumerated relate to those cases where the causes of contagion will be found to prevail in their maximum intensity. These precautions, he added, are instituted under the hypothesis, which he considers very probable, if not certain, that cholera does not enter the human organisms by the air passages, but that it does enter by the digestive canal, unless under very unusual circumstances.

1. Not to make use of the drinking-water of the locality in which the mission will be located without having previously boiled the water, and shaken it well, after it has become cold, for two or three minutes, in a bottle half filled; or the water may be put into vessels previously heated, "vases flambé"—that is to say, vessels that had been subjected to air heated to about 150° C., or even more; the higher the temperature the better. The natural mineral waters may be employed with advantage, instead.

2. Make use of wine that has been heated in bottles to from 55° to 60° C.., and which should be drunk in glasses also previously heated.

3. To make use of alimentary substances only after being well cooked, and fruits in their natural state, but previously washed with water that has been boiled, and preserved in the same vessel in which it was boiled, or had been transferred into those previously heated.

4. To make use of bread cut up into thin slices and submitted to a temperature of about 150° C., during twenty minutes or more.

5. All the vessels employed for alimentary purposes should also be previously subjected to a temperature of 150° C. or more.

6. The bed linen and towels should be plunged into boiling water and then dried.

7. The water for washing or bathing should be previously boiled, and, after being cooled, mixed with solutions of thymic or of carbolic acid, the former in the proportion of 1 to 500 parts, and the latter 1 to 50 parts.

8. The hands and face should be washed frequently during the day with boiled water, and to which should be added solutions of thymic and carbolic acid.

9. It is only in cases where the bodies of patients who have died from cholera or their soiled linen has to be handled that it would be necessary to cover the mouth and nostrils with a small mask formed of two pieces of thin plates of metal, enclosing between them a little cotton wool of not more than 1 centimetre thick, the mask having been submitted to 150° C. only, aad renewing the temperature of I50° on each fresh exposure to contagion.—*Med. and Surg. Reporter.*

Pomade for Comedones.—The *St. Louis Medical Journal* says that Una, in *Virchow's Archives*, recommended the following for comedones; Kaolin, four parts; glycerine, three parts; acetic acid, two parts, with or without the addition of a small quantity of some ethereal oil. With this pomade he covers the parts affected, in the evening, and if need be during the day. The comedones can be easily expressed after several days, most of them coming out by washing the parts with pomice-stone soap.—*Chicago Med. Review.*

CANADA

Medical and Surgical Journal.

MONTREAL, JANUARY, 1884.

THE UNIVERSITY QUESTION.

It should be the ambition of all concerned in educational matters in Canada to push forward our institutions to that stage at which they may become not merely the recipients and purveyors of current knowledge, which they are now, but centres from which may originate valuable contributions to the common stock—contributions which will make Canadian learning and research universally respected. We may reasonably claim that something towards this has already been done by Canadian workers, but two things, amongst others, sadly retard progress in this respect; first, imperfect training of teachers and professors, and second, a plurality of subjects professed and taught. It is one thing to know thoroughly and be able to teach well any given subject in a college, it is quite another thing to be able to take up that subject and by original work and investigation add to our stock of knowledge concerning it, or throw light upon the dark problems which may surround it. Many a man pitchforked, so to speak, by local exigencies into a professional position has done the former well, but, unless a man of extraordinary force, he cannot break the invidious bar of defective training which effectually shuts him off from the latter and higher duties of his position. We have, however, many men in our colleges with good records as investigators, and we hear from them but seldom on account of the excessive drudgery of teaching which the restricted means of their college compel them to undertake. The instances are few indeed in our Universities in which a professor has but a single subject to deal with, and those which do exist are in subjects of great extent

and often subdivided in other colleges. In looking over the list of branches taught by a single professor in some of our colleges we may indeed say with Dr. O. W. Holmes that he does not occupy a *chair* but an entire *settee*. If Canadian scholarship is to be fostered, if progress in science is to be made, this condition of things must be remedied, and we may confidently hope will be, as years roll on. The above remarks have been suggested by the active discussion which is taking place in Ontario about additional endowment to the provincial University. That it is needed everybody admits, and that it should be granted by the State every one will concede, unless affected with denominational myopia. Private benefaction has done much, or rather everything, for university extension in this Province, and the bequests in favour of the sectarian colleges in Ontario have been large. But unless the liberality of individuals is manifested in the manner of the late Mr. Johns Hopkins, of Baltimore, we shall have to wait long for a *fully equipped* Canadian University. The Government of Ontario, however, has now the opportunity to put Toronto University on a proper basis, and do a great work for the intellectual life of this country. And it can consistently do so, as the Institution is a State foundation and is under State control, and the condition of the local Exchequer is plethoric.

What we have said concerning checks to progress in our universities applies equally to our Medical Schools. Compared with other countries, the medical profession here is in an enviable position. We have satisfactory laws regulating the study and practice of medicine, and a general body of practitioners very much above the average. What we want now is increased efficiency in our medical schools, not only as regards teaching facilities but for the higher work of research. Canada can never take an active part in the scientific work of the profession until her schools have proper laboratories with well-paid professors and assistants to work in them—men placed above the worries and vexations of practice, and whose time will be devoted solely to teaching and investigating the subjects they profess. To accomplish this the schools must have money—much money.

That the necessary endowments will come in time we have not the slightest doubt. People are only now beginning to understand that we have needs, and what has been done is an earnest for the future. And while waiting, the duty of the hour is clear —to work honestly and faithfully with the means at our disposal, having but a single aim, and that a high one, to place Canadian medicine in a position every way worthy of our country.

PERINEAL SUTURES.

—We believe it is agreed on all hands by the modern school of obstetricians that puerperal lacerations of the perineum ought to be brought together and so maintained by sutures, immediately, or as soon as possible within a few hours after, the labor. Experience shows that it is not necessary that the sutures shall be applied immediately after the expulsion of the placenta. In our personal experience in one instance complete success followed the introduction of the sutures six hours after the receipt of a most extensive, ragged, and profusely bleeding laceration, extending through the sphincter, and some distance up the recto-vaginal septum. A variety of material for suture may be used. Silver wire, though possessing advantages, is certainly not necessary to success, and it is open to objections, not the least of which is, that it is much more painful than a more pliable material. The twisted ends of the wire catch on bed clothes and body linen, and acute suffering is thereby caused. Chinese twisted silk is equally efficient and not open to these objections. It is easier of application than wire. We have heard of a case treated with linen thread, and resulting in perfect success. These facts should be borne in mind by the obstetrician who meets with this accident far from home and his armamentarium. A darning needle and a strand of strong thread may suffice. Hitherto the interrupted suture has been exclusively used. In a recent number, (the last but one,) of the *Centralblatt für Gynækologie* (No. 49, 8th Dec., 1883) appears a short article by Brosé, Assistant Physician at the Royal University Clinic for Women, in Berlin, on the "Continuous Catgut Suture for closing Perineo-vaginal lacerations." The author claims decided advan-

tages for the continuous or furrier's suture (kürschernaht) over the interrupted suture. It is more rapidly applied, He begins at the upper part of the rent in the vagina by making one knotted suture. He then continues in a spiral. If the rent be deep it is first brought together in its deeper parts by a spiral, which prevents the formation of pockets. The same process continuously applied closes the upper parts. If catgut be used no attention need be given to its removal. At the end of the sixth day it has disappeared, and the union is firm. The thicker sorts (about No. 2 of Lister's catgut) should be used. Before and during the suture the wound is irrigated with a solution of corrosive sublimate, 1 to 2000. Afterwards it is covered with a thick layer of iodoform. Eighteen cases treated after this method are reported—all being successful. One of the cases, with a slight perineal laceration, died of peritonitis on the sixth day, but the wound had united. The method deserves a trial.

DISPENSING POISONS.

On the 12th ult. a fatal case of poisoning by carbolic acid occurred in this city. The victim was a little child suffering from diphtheria. A bottle of medicine and a bottle of pure carbolic acid stood together on the table. In the night-time the mother unfortunately mistook the bottles, and administered the acid in place of the mixture. This lamentable occurrence affords another warning of the necessity of protecting with scrupulous care the vials which contain poisons. In this case the poison was simply placed in an ordinary bottle with a poison label and directions for use. It has been shown time and again that this is not sufficient—that the majority of such accidents occur in imperfectly-lighted rooms—and that the sense of touch must be appealed to in order to warn of the present danger. Some of our chemists use rough blue bottles for all washes, liniments, and poisonous drugs. We commend the practice, and we only wish that we could see it carried out far more generally. We regret to state that many of our dispensary-houses, whose care and attention in dispensing is well recognised, still fail to avail themselves of this simple method of insuring their customers against accident.

THE SPIROMETER CASE.—At the Civil Assizes in Toronto, before Mr. Justice Rose on the 9th inst., the interesting case of Lennox *v.* McCammon was tried. Lennox is one of Souvielle's spirometer men, and has the Toronto establishment. He is a legal practitioner, registered in Ontario. At the last meeting of the Ontario Medical Council, Dr. McCammon of Kingston is alleged to have referred to the prosecutor as a "medical prostitute and quack, and as a disgrace to his *Alma Mater*." Some interesting facts came out in evidence. Instead of twenty-eight physicians employed in Toronto and Montreal, as advertised, there were only five; and of the two in the Toronto office, the address of only one could be given, a "Dr." Aiken of Weston, who had been in the Institute for a year, but whose name Dr. Lennox could not spell. As to the $250,000 alleged to be invested in the business, it could not be shown in what way. We are glad to see that the reference to Souvielle's fraudulent attempt to get the Erlangen degree was brought out publicly. Professor Rosenthal, of that University, wrote out about it, and his letter was in possession of the defence. The counsel agreed that his Lordship should enter a verdict for the defendant. If not appealed, this will dispose of the case against Dr. Bray, who was also accused of slander and libel at the same time as Dr. McCammon. We congratulate these gentlemen on the issue of the case. It will do good, as it brings out publicly the character of these spirometer men.

THE "INDEX MEDICUS."—This admirable publication appeals to the professional public for further support, otherwise it cannot continue to exist. They ask for further subscribers at either $10 or $12 per annum, according to the number who come forward. We hope that the *Index* may not be allowed to die. It would be a great assistance if the local societies everywhere would subscribe. The cost to each member would thus be small and the assistance rendered great.

THE "ARCHIVES OF PEDIATRICS."—We have received the first number of this journal, edited in New York by Dr. Wm. Perry Watson. It is a monthly and, as its name implies, is devoted to the diseases of infants and children. There is ample

scope for such a publication. The special features of infantile affections, the causes of infantile mortality, and the hygiene of young children are all subjects which do not, in our medical and surgical journals, receive that attention which their importance deserves. A number of able collaborators are associated with the editor; and amongst them we are pleased to see the name of Dr. A. D. Blackader, of this city, who gives instruction on the diseases of children in the University Dispensary of McGill College. We wish the "Archives" every success.

Brigade-Surgeon Campbell Mellis Douglas, M.D. (Edin., '61), will deliver the course of lectures on "Domestic Surgery" at the Ladies' Educational Association, in place of Dr. Roddick, who is absent in Europe. Dr. Douglas, who is a native of Quebec, has had a distinguished career in the army, which he joined in 1862. He is one of the few non-combatants with the Victoria Cross, with which he was decorated, together with four privates of the 24th, "for the very gallant and daring manner in which, in May 7th, 1867, they risked their lives in manning a boat and proceeding through a dangerous surf to the rescue of some of their comrades, who formed part of an expedition which had been sent to the island of Little Andaman, and by which 17 officers and men were rescued from a fearful risk, if not sudden death."

Obituary.

CALVIN ELLIS.—Dr. Ellis, Professor of Clinical Medicine in Harvard University, and late Dean of the Medical Faculty, died on the 14th ult., after a prolonged illness, at the age of 47. He was appointed to the chair of Clinical Medicine in 1864, succeeding Dr. H. I. Bowditch, and soon became one of the foremost among the teachers of medicine in the United States. A more thorough or painstaking instructor there could not have been. We have had, on several occasions, the pleasure of listening to his lectures and clinical conferences. The latter, peculiar, we believe, to Harvard on this continent, were models, and displayed the earnest, conscientious teacher, sparing neither time nor labor, so long as the student was benefited. For many years he had abdominal trouble, which, some two or three years ago,

he diagnosed as duodenal ulcer. Death occurred from perforation and peritonitis. He has left $50,000 to Harvard for scholarships.

DR. BEATTY, of Lambton, died suddenly on the 26th ult., of heart disease. As coroner for the district, he was holding an inquest on the body of an old woman, supposed to be murdered. He was a Licentiate of the Provincial Medical Board of 1852, and an M.D. of Victoria, 1856.

DR. A. A. RIDDEL, of Toronto, died on the 15th ult., aged 64. For many years he was coroner of the city. He was a Licentiate of the Upper Canada Medical Board of 1857. For some years he practiced in Mexico.

Personal.

Dr. Clarence J. Chipman, late of Prescott and Cardinal, has removed to Ottawa.

Dr. Griffin has been elected President of the Medico-Chirurgical Society of Hamilton.

John Smith, M.D. (McGill, '79), has left Emerson, Man., and is at present in Portland, Oregon.

Dr. Buchan, of Toronto, has succeeded Dr. Lett as Assistant Superintendent of the Toronto Asylum.

Dr. F. A. Dion, of St. Saveur, has been appointed Inspector of Anatomy for the district of Quebec.

B. F. W. Hurdman, M.D. (McGill, '82), has returned from England, and has begun practice in Inverness, P.Q.

Dr. Bell, of the General Hospital, was called to Winnipeg on the 3rd, by the sudden death of his brother in that city.

Dr. F. S. Greenwood, St. Catharines, has been appointed attending physician (with salary) to the City Hospital.

We are glad to hear that Dr. Lafontaine B. Powers, of Port Hope, has recovered from his recent illness, and is attending to his duties.

D. G. Inksetter, M.D. (McGill, '80), has given up his practice in Dundas, Ont. He purposes taking an extended course

in England before settling again. His partner, James Ross, B.A., M.D. (McGill, '81), continues the practice.

The many Canadian friends of Dr. Seguin, of New York, will be glad to learn that he has resumed practice at 47 W. 45th Street.

Dr. Winstanley, one of the oldest and most respected practitioners of Toronto, is about to remove to Southern California for his health.

Richard Price, V.S. (Montreal), has been appointed Lecturer on Materia Medica in the Northwestern Veterinary College, Minneapolis, of which Dr. Lyford is the Principal.

Kenneth Mackenzie, M.D. (McGill, '81), has been appointed Professor of Anatomy in Willamette University, Portland, Oregon, and Surgeon to St. Vincent's Hospital, in the same city.

Dr. Beaumont Small is President this year of the Ottawa Field Naturalists' Club. The Doctor delivered the first lecture of a series to be given in connection with the Society, on "The Study of Natural History."

Medical Items.

—The tenders have been let for a new City Hospital at Charlottetown, P.E.I.

—Enemata of chloral hydrate as said to be useful in the vomiting of pregnancy.

—We regret to learn that Seguin's *Archives of Medicine* has been discontinued. The *Archives of Laryngology* has also succumbed.

—The committee appointed last year to revise the curriculum of the Ontario Medical Council met in Toronto on the 27th ult., and decided upon the amendments to be submitted to the Council.

—His Excellency Dom Smeulders, the Papal Commissioner, began on the 7th to take the evidence of the Professors of the Montreal Branch of the Laval School, in connection with the Laval-Victoria trouble.

—Depaul recommends the administration of iodide of potassium during pregnancy, in cases of contracted pelvis, with a view of lessening the size of the child.

—Taking advantage of the abundance of material, nearly 90 of the junior students of McGill College spent the Christmas vacation working at the extra subjects usually "brought up" at this time.

—Sponging the surface of the body with a solution of quinine in alcohol—one drachm to the pint—is now recommended for excessive sweating. It is a remedy that has long yielded us good results.

LAVAL UNIVERSITY, QUEBEC.—Dr. Jackson has been appointed Dean of the Medical Faculty; Dr. Verge, Professor of Medicine; Dr. Wells, Professor of Materia Medica; Dr. D. M. Brochu, Professor of Hygiene.

HEAVY BRAIN.—The brain of Turgenieff, the Russian novelist, weighed—so it is said—2012 grammes, one of the heaviest on record. In the *Edinburgh Medical Journal* for November a case of brain tumor is recorded; the brain weight was unusually high, 67 ozs.

MCGILL MEDICAL SOCIETY.—*Nov. 17th*—Mr. Renner read a paper on "Tumors of the Breast," giving the characters and diagnostic signs of the chief growths in this region. Mr. Wyat Johnston exhibited a number of Pathological specimens, and Dr. R. J. B. Howard a series of microscopic slides of breast tumors. *Dec. 1st*—Mr. J. A. Hutchison read a paper on "Some sequelæ of Diphtheria," giving the details of a number of cases. Mr. Darey gave a reading from Thackeray. *Dec. 15th*—Mr. C. E. Gooding, of Barbadoes, read a paper on "Elephantiasis," dealing specially with the relation of the Filaria to the disease. A slide of blood showing the parasite was exhibited. Dr. Osler made some observations on the relation of Filaria to Chyluria. Mr. Rowell gave a report on a case.

HALIFAX DISPENSARY.—The following are the physicians to the Dispensary for the year 1884. The old staff were reappointed with the exception of Dr. D. A. Campbell, who retires voluntarily, viz:—Attending physicians, Drs. Rigby, Somers and McFatridge. Visiting—North District: No. 1, Dr. Marshall; No. 2, Dr. J. S. Lathern, vice Campbell. Central: Dr. Lindsay. South: Dr. Trenaman. Apothecary, Dr. Harrington. Dartmouth—Attending and Visiting: Dr. Cunningham, reappointed.

UNIVERSITY OF MANITOBA.—The committee of the Board of Studies, having met the representatives of the Manitoba Medical College, has recommended for adoption a statute on the degree of M.D. The requirements set forth are practically identical with those of other Canadian Universities. The matriculation examination differs in some respects from that recommended by the British Medical Council, but is sufficient to test the proficiency of the candidate, indeed, with ten papers, to each of which three hours are assigned, will be more extensive than usual. The committee also recommends the affiliation of the Medical College and the granting of representation on the Council of the University.

THE BUFALINI PRIZE.—Some of our philosophical readers may be interested in the following particulars, recently received, concerning this prize. The late Professor Buffalini, a learned physician, of Florence, being convinced that all principles of reasoning called *a priori* are entirely false, and that only the philosophy called experimental is true, appeals now, ten years after his death, to the learned, and will continue to appeal every twenty years for a solution of the following problem, for which a prize amounting to $965 is offered:—"The necessity of the experimental method in arriving at the truth and the relation of all the sciences being assumed, it is required to demonstrate in a first part how far the said method is to be used in every scientific argument, and in a second part to what extent each of the sciences has availed itself thereof during the time that has elapsed since the last competition for a prize, and how they may be brought to a more faithful and complete observance of the method itself."

MUNICIPAL HONORS.—The following members of the profession in Ontario have been elected to municipal positions for the year;—

Mayor—Dr. McCammon, Kingston; Dr. Rae, Oshawa; Dr. Bogart, Whitby; Dr. Standish, Palmerston.

Reeve—Dr. Willoughby, Colborne; Dr. Bradley, Kincardine; Dr. Mitchell, Wallaceburg; Dr. McConnell, Brockton; Dr. Allan, Arthur; Dr. Means, Petrolia.

Councillors—Drs. Black and Bascom, Uxbridge; Dr. Walker Dundas; Dr. Harris, Brantford; Dr. Cook, Chesley; Dr. Gillespie, Cannington; Dr. Webster, Esquesing; Dr. Henry, Hamston; Dr. Tennant, Lucknow; Dr. Doherty, Markham; Dr. M. S. Scott, Southampton; Drs. Mathieson and Sinclair, St. Mary's; Dr. Burns, St. Thomas; Dr. Goodman, St. Catherines; Dr. Aikman, Windsor.

—We regret to see that Dr. J. Collins Warren announces that he has, in conjunction with Dr. George Shattuck, examined the essays in competition for the prize of $1000 offered on the subject of "Cancer, and the probability of the discovery of a cure of malignant disease," and cannot recommend any of them as worthy of the prize.

—At a meeting of the Board of Health last month, the following resolution was presented by Judge Dugas, and unanimously adopted:—"That in order to obtain a better knowledge of the sanitary state of the city, a circular be addressed to all the physicians of Montreal and surrounding municipalities, requesting them to make known to this Board the result of their experience concerning the extent of the ravages of Syphilis and of venereal diseases in general; to state whether they consider it opportune to establish restrictive measures for the prevention of those diseases, and what, in their opinion, would be the best means to be adopted for that end." We learn from Dr. Larocque that about thirty replies have been sent in, the general tenor of which is that the disease is very prevalent, and that restrictive measures are necessary.

—Baronetcies have been conferred on Mr. Joseph Lister and Mr. William Bowman. There are now nine medical baronets,

all London practitioners. Four are physicians, viz., Burrows, Gull, Jenner and Clark. Five are surgeons, viz., Paget, Wells, Hewett, Lister and Bowman. Of Knights Batchelors, there are also nine, viz., Risden Bennett, Birdwood, Carroll, Cooper, Lentaigne, McCormac, Salmon, Thompson and Erasmus Wilson.

—It is always pleasing to notice a piece of solid scientific work done in the country. We see in the last number of the *Quarterly Journal of Microscopical Science*, of London, Eng., a valuable memoir on "The Osteology and Development of Syngnathus," by Professor Playfair McMurrich, of the Guelph Agricultural College. It is an able contribution to the morphology of the lophobranchiate fishes. Mr. McMurrich is one of a band of able workers at Biology, which has been trained by Professor Ramsay Wright, of University College, Toronto.

—It is asserted that carbolic acid, in the proportion of one part to one thousand, will keep solutions of atropia and eserine clear, and prevent the formation within them of a fungous growth, to the septic action of which the conjuctival inflammation, which is sometimes set up by the use of old atropia solutions, has been ascribed. Carbolic acid in this proportion produces no disagreeable sensation in the eye, and it is much more efficient than either salicylic or boraic acid, which have been used for the same purpose.

—"Well," remarked a young M.D., "I suppose the next thing will be to hunt out a good situation, and then wait for something to do, like Patience on a monument." "Yes," said a bystander, "and it won't be long after you do begin before the monument will be on patients."—*Phil. M. & S. Reporter.*

—Dr. Carl Seiler, Lecturer on Diseases of the Throat, University of Pennsylvania, Philadelphia, Pa., says:—"I have used the preparation called BROMIDIA, as manufactured by Battle & Co., of St. Louis, both internally and locally by means of a spray, in cases of throat affections, and found it admirably suited to certain cases."

CANADA

MEDICAL & SURGICAL JOURNAL

FEBRUARY, 1884.

Original Communications.

FIBROIDS COMPLICATING PREGNANCY — DIFFICULTIES IN DIAGNOSIS—AUTOPSY.

By EDWIN GOODMAN, M.B., St. Catharines, Ont.

A friend, to whom I sent a brief and incomplete description of the following case, has requested me to furnish notes of it for publication. As it possesses features of diagnostic interest I have decided to comply with his request:

Mrs. Y—, the subject of the subjoined sketch, was a mulatto woman, aged about 30 years. She was of slender form, bright, energetic, active in her habits, and quite healthy. She was the third wife of a robust Anglo-African, who is no doubt quite competent to discharge efficiently his marital duties, as he has had several children by a former spouse. Up to June last Mrs. Y— had menstruated regularly. She had never suffered from dysmenorrhœa, or amenorrhœa, and only once from menorrhagia, in November, 1882. She flooded profusely on that occasion, and was rather alarmed in consequence; but she soon rallied from the depressing effects of the loss of blood, and continued to menstruate regularly, and quite normally, until early in June, 1883. There was no regular menstrual flow after that date; but on a few occasions a small clot of blood was expelled from the vagina. In other respects she was entirely free from any abnormal symptoms, or sensations, referable to the uterus or its appendages, if we except slight nausea in the mornings, and occasional incontinence of urine. This condition of affairs continued from the first of June, 1883, to some time in the

month of August, 1883. She then began to experience a sensation of fullness in the hypogastric and left iliac regions, and at length became conscious of the presence of a hard, round tumor, about the size of a cricket ball, and nearly as hard, just behind and slightly above the *symphysis pubis*. The tumor became gradually more and more prominent, and continued to grow apparently higher up towards the umbilicus. The patient and her husband at length became alarmed, and I was called in to see her. I was much puzzled. The cessation of the menstrual flux, and the subsequent development of the tumor, suggested the idea that the woman was pregnant. The tumor did not feel, however, like the gravid uterus. It was too hard and dense, too prominent and clearly defined; it actually seemed to be just under the skin of the abdomen, and the greater portion of it could be grasped by the hand and fingers. Behind the tumor, and deeper in, towards the supposed locality of the fundus uteri, smaller moveable tumors, or, perhaps I should say, masses of some kind, could be felt, conveying the impression exactly of the extremities of a fœtus. These little objects could be almost examined in detail by the fingers, through the attenutated walls of the abdomen. The cervix and os uteri were normal in appearance, and in position, and had undergone no change indicative of existing pregnancy. The left side of the uterus felt harder than the right on pressing the finger high up towards the body of the uterus from the vault of the vagina. But the right side of the uterus seemed to occupy the largest space, and was lower down in the pelvis; it could be easily felt through the vaginal walls in the Douglas' *cul de sac*, and also to the right of the cervix. I did not, at my first examination, use the sound, as I feared the existence of pregnancy. I thought, however, that it could not be a normal pregnancy, but that from the prominence of the tumor, and the ease with which I fancied I could detect the outlines of the fœtus, that it must be a case of extra-uterine fœtation. On the other hand, the patient had had no pains such as usually accompany extra-uterine pregnancy; and neither I, nor any of my medical friends, including Dr. Trenholme of Montreal, were able to

detect by means of the stethoscope either the sounds of the fœtal heart or the placental souffle ; and moreover, the patient never, at any time, was conscious of fœtal movements. In October, 1883, the case was carefully examined by my *confrères*, Dr. Trenholme, of Montreal, and Dr. Downey, of this city. Acting on the advice of Dr. Trenholme, I introduced the uterine sound, no evidence of fœtal or placental circulation being discoverable by the stethoscope. The sound passed between three and four inches in the normal direction, and was then arrested. We all three passed the sound, and were all of the opinion that its point had reached the fundus uteri, and that consequently its cavity could not contain anything of sufficient dimensions to account for the size of the abdominal tumor. Dr. Trenhelme diagnosed the existence of uterine fibroids, and subsequent events, as I shall proceed to show, have verified that diagnosis. I could not divest my mind of the existence of pregnancy in addition to the tumors, on account of the rapid growth, and remarkable prominence of the uppermost tumor, which felt so much like the head of a fœtus. And because, in my experience, every case of fibroid disease of the uterus had been accompanied by more or less menorrhagia, which had never been present save on one occasion, in November, 1882, as above stated. However, I took it for granted that I must be mistaken. And as it was necessary to do something to satisfy the patient and her husband, I gave ergot in small doses two or three times daily for several weeks, and directed that tincture of iodine should be applied over the swelling. The patient continued to enjoy excellent general health, and kept on discharging her active duties as manager of a restaurant. She never felt any pain, and only complained that the pressure of the tumor was somewhat annoying, and that she had difficulty in retaining her urine. She also said that on a few occasions a small clot of blood had passed from her vagina. The tumor instead of diminishing under the influence of the ergot and iodine seemed to thrive upon them, and gradually reached nearly to the umbilicus. At length the patient and her husband again became restive and uneasy, and wanted " something

done." So on the 10th of January inst., accompanied by my friend, Dr. Comfort, I again carefully examined the patient. I found the tumor much higher up than before, but not apparently much larger. There seemed, however, on making a vaginal digital examination, to be a large, rather soft, and somewhat irregular tumor behind and to the right of the cervix uteri, above the vaginal vault. We could both feel, with remarkable distinctness, what seemed to be the outlines of a fœtus through the abdominal walls. We again tried to detect signs of fœtal life through the stethoscope, and again failed; for good and sufficient reasons, *this time*, as will be seen later on. I then, through the speculum, introduced the uterine sound, and to my astonishment passed it readily up to the handle at least eight inches. I then gave the sound to Dr. Comfort; he could only introduce it about the normal distance. I then disengaged the point, and after a little manœuvering managed to circumvent the hitherto insurmountable obstacle, and the Dr. readily passed it up as far as I had done. We then decided to puncture the tumor with a hypodermic needle, to ascertain what it contained. There was a small escape of perfectly clear, limpid fluid, which we then took to be liquor amnii, but which I now think could only have been the normal serum secreted by the peritoneum. On Saturday evening, the 12th inst., severe pains, exactly like labor pains, set in. I must honestly confess I could not yet divest my mind of the idea that the case was one of extra-uterine fœtation, or that there was a double uterus. I could not otherwise account for the two apparent cavities, of different lengths, into which the uterine sound passed, or for what seemed like a flow of liquor amnii from the punctured circumscribed tumor. I dreaded the result of the labor pains. On Sunday morning while taking breakfast, after having been up all the previous night with a normal case of labor, I was called hurriedly to see the patient, and informed that "one of the child's feet was born." I was surprised and delighted at the news, and immediately went to my patient. True enough, one foot was protruding from the ostium vaginæ. The fœtus, about six and a half months, uterine

life, was large, and partly decomposed, having evidently been dead for some time. I had great difficulty in extracting it, but succeeded at length. The fœtor was something dreadful. The umbilical cord was so much decayed that it broke off at the navel, and the placenta, also partially decomposed, was adherent. I had a difficult and unsavory job in separating it from its attachments. While my hand was in the uterus I could feel that the cavity of the uterus was encroached upon somewhat from the left side, and that it trended, as it were, over towards the right side of the abdomen. The patient bore her sufferings like a heroine. She soon rallied from the shock. The lochial discharge was rather darker than normal, but not excessive, nor unusually offensive. She seemed to do splendidly for several days; had a good appetite, no pain, no fever, and was in excellent spirits. On Sunday, however, the 20th inst., she had several chills, followed by feverish symptoms. On Monday she noticed a puffy swelling on the back of one of her hands, and complained of weakness, restlessness, loss of appetite and sleeplessness. Her pulse was small and rapid. Her breathing shallow and hurried. There was a flush on her cheek, jactitation of the muscles, and rigidity of the muscles of the throat and jaw. She had difficulty in speaking, and her muscles were tremulous, with defective power of co-ordination. In a word, she had been stricken with septicæmia, and was about to die, which she did on the morning of Saturday, the 26th inst.

At the autopsy I was assisted by Dr. Comfort and Mr. Macrae, a student of McGill College, Montreal, and unravelled the mystery which had puzzled us so long. On opening the abdomen we discovered that the pelvic peritoneum was injected in places, and that recent coagulable lymph had been effused to a slight extent. The uterus was removed entire and examined. Its involution had been going on favorably, for the cavity, from the os to the fundus, did not exceed eight inches. The walls of the uterus were softened considerably, and undergoing fatty degeneration. The round tumor which had been felt through the walls of the abdomen was discovered to be a fibroid tumor, sessile, attached by a broad base to the anterior aspect of the

uterus, and a little to the left. Another *very large fibroid* was found in the walls of the uterus on its left side, *intramural*. It was *against this tumor that the end of the sound impinged when we supposed that we had reached the fundus;* for it projected considerably, and encroached upon the cavity of the uterus. It was this tumor that pushed the contents of the uterus and the right wall of that organ over towards the right side of the pelvis. It was the growth upward and forward of the gravid uterus that caused the tumor on the anterior aspect of the uterus to project so prominently, just over the *symphysis pubis*. The cavity of the uterus containing the fœtus lay behind this tumor, and extended somewhat above it. Besides these two large tumors, there were several small tumors, of about the appearance and size of white beans, on the anterior, posterior, and lateral aspects of the upper part of the body of the uterus.

It requires a certain amount of moral courage to recount one's mistakes in diagnosis. Mistakes, however, will occur, even to the practice of men of vastly greater acumen and experience than the writer possesses; and they should be utilized as a warning, and as a mode of instruction to one's self and others. It is for this reason, and because I have been asked by a friend, whose request I do not like to disregard, that I have committed the above facts to writing.

ACONITE IN DIPHTHERIA.

By M. CHISHOLM, M.D., Bay Roberts, Nfld.

Read before the Conception Bay Medical Society.

Mr. President and Gentlemen,—In coming before you now with a paper on the treatment of diphtheria, my aim is not so much to inform as it is to be informed; not so much to teach new methods of treatment, as it is to test them. I come before you in the interests of our art. I court criticism, and shall receive it in the spirit of one who is ever ready to be instructed.

The administration of aconite in threatening inflammation is urged by the highest authority. Its use in diphtheria is never alluded to, even by those of eminent standing, who look upon

the disease as purely innflammatory like croup. Not committing myself to this view, nor yet to the germ theory, I shall go on to shew, that the use of aconite in the first stage of diphtheria, is not only eminently successful, but clearly rational.

CASE 1.—On the morning of November 4th, 1881, I was asked to prescribe a gargle for an absent person complaining since the 3rd of sore throat. I gave a mixture of Pot. Chlor. slightly acidulated with Acid. Hydrochlor. In eight hours I was summonded in haste to see the same patient. He had grown rapidly worse. I found a strongly built boy of 13 with a temperature of 105°, pulse 150, unable to speak or sit up, delirious and becoming comatose. The breath was offensive. Submaxillary glands swollen and tender. Mouth parched, tongue red and glazed, fauces dry, swollen and livid, tonsils congested but not coated. From the semisensible condition of the patient, I had much difficulty by lamp light in examining the throat. Repeated efforts failed to shew any membrane, still the swollen glands, the deeply congested fauces and tonsils, with the offensive smell and prevalence of diphtheria, led me to diagnose diphtheria of the severest tpye.

Treatment.—An emetic of Ipecac, and Tinct. of Aconite ♏xx, Pot. Chlor. ʒii, Aqua ad Oj, of which take one teaspoonful every 10 minutes.

Nov. 5th.—Delirium gone; articulates better; T. 102°; P. 115 and fuller; tongue and mouth moist and less congested; tonsils nearly all covered very thinly with membrane which spreads anteriorly on the fauces; changed for the better four hours after giving the medicine.

Nov. 6th.—Much better; disposed to eat; T. 102° still, but a copious glairy discharge from mouth and fauces; spread of membrane checked.

Nov. 7th.—Improvement continues; membrane breaking up; throat clearing. *Sig.* original gargle with an occasional dose of Aconite and Pot. Chlor.; to keep warm in bed. Saw him once more, when he was quite convalescent.

CASE 2.—A. B., age 8; sick three days; brother dead a week of diphtheria; found him with nurse; pulse 156; tem-

perature very high; countenance dusky; ashy about eyes; kept getting worse in spite of ordinary remedies; throat much swollen and coated. *Sig.* Aconite mixture every 10 minutes in drachm doses. Next morning pulse 120; fever much reduced and perspiring; livelier. Membrane not spread; changed for the better six hours after giving medicine.

℞. Tr. Fer. Perchlor 3ii; Pot. Chlor. 3i; Aquæ ad Oj. *Sig.* one teaspoonful every 30 minutes; also the Aconite mixture in smaller doses. After this the child rapidly recovered.

CASE 3.—Much like No. 2, but that on discontinuing the Aconite, after getting the fever down, and substituting the Iron mixture, the fever went up again and the patient got so much worse that I was called again to see him. I stopped the Iron and renewed the Aconite with excellent effect as at the first. I then presented both mixtures as in case No. 2 and the child rapidly recovered.

The remainder of this Aconite mixture was given without my knowledge to a neighbor's child, and in the mother's words cured it in no time.

It may be that popular opinion is of little account apart from the pocket, but my medicine acquired some fame, and I often dispensed it to the poor in powder, the Potash being saturated with ♏x Flem. Tinct. Aonite, giving orders to dissolve in Oj of water, keep cool by the addition of ice, and give as above.

It may be affirmed, and from my experience except that of case 1, I am not prepared to deny that Pot. Chlor. alone would do as well. Of this, however, I am certain that a combination of both remedies, given as above in ice cold water, has as marked an influence for good in diphtheria as it sometimes has in the threatening stages of Tonsillitis or Pneumonia. Nor when I say so, need your countenances assume that mingled form of scepticism and derision, which the mention of my treatment drew from one of our Æsculapian devotees in St. John's. I have used it in over 100 cases, and I never saw anything but improvement result from it. I never saw its use followed by that profound blood poisoning so often fatal under every other treatment. I have, on the other hand, certainly averted it,

and lost patients where it was not prescribed. While using it I never lost a case except as a result of cold from exposure, ending in croup, after the throat symptoms subsided or completely disappeared.

Now as to the *modus operandi* of Aconite. Supposing, with some, that diphtheria is purely inflammatory, like croup in its onset, and that the systemic affection is secondary to the local disease, then, on the authority of Ringer, there is no medicine able to check inflammation like Aconite in small doses frequently repeated; and if this curative action of Aconite holds good in one acute disease, why not also in diphtheria. A writer in the *Practitioner* (1879) treating of Aconite in Pneumonia thus accounts for its therapeutic value. In minute doses, and not too long continued, it depresses the sympathetic and contracts the vaso-motor fibres. By the first action it lowers the reaction of febrile excitement, and gives nature a chance to assert its powers. By contracting the vaso-motor system, especially where the parts are rendered more susceptible by inflammation, it is directly anti-inflammatory. If, then, the disease be local in its origin, how important it is to use a remedy which has the power of preventing the formation and circulation through the system of products so destructive as are those of diphtheria.

But if the disease be systemic, as the researches of M. Talamon, in the Hotel Dieu of Paris, and of Pasteur in a different field, would seem to demonstrate, then Rational Therapeutics would protect the tissues, get rid of the germs, and support the strength.

Now, in Aconite we have a remedy which answers the first two of those indications admirably. 1. It is as before proved directly anti-inflammatory, and any control we can exert over inflammation in a part so constructed as the throat is, can scarcely be over-estimated. 2. By depressing the sympathetic the exciting influence of an inflamed part over the general system is lessened, the circulation is quieter, the temperature is lowered and tissue change is retarded. In the words of Cullunore who, through the *Lancet* (Oct., 1882) reports a case of Rabies successfully treated by Aconite: "It reduces the inter-

change between the morbid blood and those tissues, upon whose irritation depends the fatal manifestation of the disease."

Aconite fulfils the 2nd indication by relieving the system from the incubus of febrile excitement, favouring the *vis medicatrix naturæ*, in inducing profuse diaphoresis by which the poison is eliminated, and giving time for the successful operation of more potent germicides.

The 3rd indication is involved in the first two. It preserves the strength by conserving it, and in the small doses above indicated is never followed by depression even though continued for over 24 hours, as in case 1. Of all I have advanced this is the sum, and I am done.

1. Aconite in minute doses, frequently repeated, depresses the sympathetic, and like cold, contracts the vaso-motor fibres.

2. It has a selective action on inflamed parts, because of their increased susceptibility.

3. This sedative effect by lessening febrile reaction is conservative of strength, while its vaso-motor action is anti-inflammatory.

4. In consequence of this twofold action, Aconite in at least the first stage of diphtheria calms the circulation, lowers the temperature, lessens tissue change, overcomes inflammation, checks the spread of membrane and helps the relieved system to throw off the poison through the skin and kidneys.

IODOFORM.*

By JAMES STEWART, M.D.,
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Although it is sixty years since iodoform was discovered, its general employment as an antiseptic agent dates back only three years. At the present time it is—carbolic acid not excepted—probably the most extensively used agent of any of the whole group of antiseptics. It is a teriodide of formyl (CHI), and is prepared by adding chlorinated lime to an alcoholic solution of iodine until the liquid ceases to present a red color.

Properties.—It is in yellow, pearly crystals. It has a sweet taste, and a persistent disagreeable odor resembling that of

* Lecture delivered before the Materia Medica Class.

saffron. It is insoluble in water, but dissolves readily in ether (1 to 7), chloroform, rectified spirits, oil of eucalyptus, collodion (1 to 10), and in vaseline.

Absorption and elimination.—Iodoform is not very readily absorbed from the intestinal canal. Although containing 97 per cent. of iodine, its properties are very different from those of the latter; the radicle formyl that enters into its composition modifies its action. This is the reason that it possesses anodyne, and not irritating, properties, as does iodine. When iodoform is introduced into the stomach, it undergoes a change into iodine. On this point all are agreed; but what particular form of iodine it assumes is a matter in dispute. Binz holds that it is in the form of iodides and iodates; while Högyes maintains that it is in the form of an albuminate. In fatal cases of iodoform poisoning, iodine has been found in the brain, in the liver, and in the kidneys. Iodoform is eliminated from the body in the form of iodine. Its elimination takes place very slowly. It is not infrequent to find iodoform in the urine three and four weeks after ceasing to use iodoform dressing. The addition of salt to the diet hastens its elimination considerably. In wounds which are in a state of putrefaction, the conversion of iodoform into iodine takes place much quicker than when it is brought into contact with "sweet" wounds. This is owing to the presence of oxydizing substances in the products of putrefaction.

PHYSIOLOGICAL ACTIONS.

Its Influence on Micro-Organisms.—Iodoform is one of the most powerful agents that we possess in preventing decomposition from taking place in fluids, and in arresting it when it has set in. It prevents the development of organisms in such fluids as alkaline urine, blood, and a solution of peptones. In contact with wounds, it has a very prompt and thorough antiseptic action, being exceeded by no other antiseptic agent.

ACTION ON MAN AND ANIMALS.

External action.—When iodoform is rubbed on the skin, it is readily absorbed into the blood. It does not give rise to any inflammation or irritation of the skin. Even when dusted over

a sensitive wound, it seldom gives rise to any irritation. If too freely dusted on a wound, it may be absorbed in such quantities as to produce death.

Action when taken internally.—In medium doses, it seldom proves irritating to the stomach and intestines. As far as is known, it has no action on either the liver or pancreas. When absorbed into the blood, it has the power of destroying the amœboid movements of the white cells, and of preventing their emigration into the tissues of an inflamed part. It is considered to have the power of increasing the number of red cells, but its blood restoring qualities are so inferior to iron, arsenic and phosphorus, that there is no field for its use as a hæmatinic.

Action on the circulation.—Iodoform has a very similar action to chloroform on the heart, but more powerful. Ringer has shown that one-fifth of a grain is sufficient to arrest the ventricle of a frog's heart, while it takes two minims of chloroform to bring about a like result. When absorbed in large quantities in man, it produces weakness, with great increase in the frequency of the pulse. Iodoform has no special action on the respirations.

Temperature.—From the use of ordinary doses, the temperature is slightly increased, but when absorbed in toxic quantities, this increase is very marked.

Nervous System.—In ordinary medicinal doses, with the exception of causing headache, there is no perceptible action from its use. In man, its anæsthetic properties are not noticeable. In cats and dogs, however, even in doses short of producing intoxication, it readily induces sleep. Its action in toxic doses on the nervous system will be considered under the head of untoward effects.

On the Kidneys.—When it is used for some time, it occasionally gives rise to a transient albuminuria.

SURGICAL USES.

Iodoform is very extensively used at present as an antiseptic in the treatment of all forms of wounds. Compared with carbolic acid, it possesses some advantages and some disadvantages. Its principal advantage is its freedom from irritating qualities.

When speaking of the uses of carbolic acid, I mentioned that it gave rise to a considerable amount of irritation, and that it was usually necessary to protect a wound from its irritating influences by interposing a piece of "protective." Now, in treating a wound with iodoform, no such precaution is necessary. We can apply it directly to the wounded surface, and have no fear of its producing any irritation. Its disadvantages are its non-solubility. As it is insoluble in water, it cannot be used in the form of spray; neither is it adapted for the irrigation of a wound, the washing of the skin, or for the cleansing of the instruments. Another disadvantage is its non-volatility. It will only destroy organisms that it comes directly into contact with. It does not, like carbolic acid, exercise any influence beyond its seat.

When iodoform was first used as a dressing for wounded surfaces, it was considered to be free from danger, and on this account it was used very freely, being dusted into abscess cavities in enormous quantities. As a result of this practice, cases of iodoform poisoning were not infrequent, many of which proved fatal. At present, however, it is quite uncommon to see cases of iodoform intoxication resulting from the dressings of wounds. It is in all probability less apt to be followed by untoward symptoms than carbolic acid.

Iodoform is used either in the form of powder or gauze in the treatment of wounds. In the majority of cases, especially of open and deep-seated wounds, the gauze is preferable to the dusting of the powder. In Billroth's klinik, the gauze is used in two forms. There is what is called *hydrophile* and *adhesive* gauze.

The *hydrophile* gauze is made by simply dusting ordinary gauze-cloth, from which all fatty matters have been removed, with iodoform. The cloth is spread out in a large flat vessel, the precaution being taken of thoroughly making this antiseptic with a 1 in 20 solution of carbolic acid before placing the gauze in it; the iodoform is then dusted over the cloth, and afterwards thoroughly rubbed in with the hands (which should be previously washed in a 1 in 40 solution of carbolic acid) until the gauze assumes a uniform yellow color. The excess of iodoform is re-

moved by shaking. It should be kept in well stoppled bottles. The quantity of iodoform contained in gauze prepared in this way varies from 10 to 15 per cent. It takes about an ounce and a half to impregnate 20 yards of cloth. This form of iodoform gauze can be used for the immediate antiseptic covering of all wounds except those about the cavity of the mouth. When it is necessary to pack an abscess cavity or a compound fracture wound, the gauze should be cut into narrow strips and introduced with a forceps. It is a good absorbent, and, therefore, does not give rise to any retention of the secretions, and being free from irritating qualities, it does not increase the amount of serum from a wound as does carbolic acid. Symptoms of intoxication of a severe degree have not been reported from the use of iodoform in this form.

The *adhesive* form of gauze is made in the following way :— To impregnate 20 yards of cloth, 100 grammes of resin are dissolved in 1200 grammes of alcohol, to which 50 grammes of glycerine have been previously added. The gauze is drawn through this mixture, dried, and then dusted with 250 grammes of iodoform, in the same way as the hydrophile gauze is prepared. The adhesive gauze is specially adapted for the treatment of operation wounds about the cavity of the mouth. It is not safe to use the hydrophile gauze in this situation, as it may become displaced and be swallowed during sleep. This accident happened several times in Billroth's klinik.

Iodoform is certainly the most efficient antiseptic in such operations as removal of the upper jaw and excisions of the tongue. It is a well known fact that septic processes (septic pneumonia, gangrene, etc.) are very apt to follow these operations, and since the introduction of iodoform, the mortality from these causes is very much less than it formerly was. This is Billroth's experience. The method of dusting wounds about the cavity of the mouth with iodoform is considered by some of the German surgeons to be not entirely free from danger ; particles of the iodoform find their way into the air-passages, and there set up pneumonia—not, of course, a septic pneumonia, but what is now commonly called " foreign-body pneumonia." Iodoform,

whether used in the form of powder or in the form of gauze, is better adapted for the treatment of all wounds that cannot be completely closed, while carbolic acid is preferable for wounds whose edges can be brought together.

In the treatment of compound fractures, narrow strips of hydrophile gauze should be introduced into the wound until the cavity is completely filled up, and over this should be placed several layers of absorbent wool. A dressing of this kind can be left undisturbed for many days.

Iodoform is one of the most efficient means we have of rendering old ulcers antiseptic. Recently great advances have been made in the treatment of tuberculosis of joints; formerly many joints and even lives were sacrificed because the nature and treatment of these cases were misunderstood. Now, however, if a case is seen sufficiently early—that is, before the joint structures are irretrievably damaged—there is a fair chance of giving the patient not only a useful limb, but also a fairly useful joint, and, further, there is removed a local disease which, sooner or later, if left unmolested, would have been the means of infecting the general system. The method of treating these cases is as follows: The diseased structures are first scraped away by means of a spoon, and the cavity left is packed with hydrophile iodoform gauze; the joint is then fixed in an immovable apparatus. The gauze is only changed when the discharge has made its appearance externally. By carefully following out this line of treatment, it is surprising what wonderful results can be obtained. Whether the iodoform in these cases exercises any special action or not is a disputed point. Billroth firmly believes that it possesses an influence beyond its antiseptic powers in these cases. He believes that it has marked *antituberculous* properties. This opinion is for the most part based on the fact that no other antiseptic agent has such a beneficial action in these cases.

A mixture of iodoform in glycerine, one part of iodoform to ten of glycerine, is a good injection into an abscess cavity after the pus has been evacuated.

Iodoform-collodion, in the proportion of one part of iodoform

to ten of collodion, is a very useful dressing for small wounds, such as those about the face, where it is not convenient to use the usual dressings After all hemorrhage from a wound of this kind has been arrested, and the edges united with sutures, the iodoform-collodion is painted over it and for some distance from its edges. It is important to have the bleeding completely arrested before painting it on. Under this coat of iodoform the wound heals without any irritation. In a week it can be scraped away and the stitches removed. The small points left after the removal of the stitches should be painted. This method of treat-treating face wounds is to be particularly recommended when erysipelas is dreaded.

Iodoform bacilli are exceedingly well adapted for making putrid sinuses antiseptic. The bacilli can be made of any thickness or length to suit the particular case it is intended to treat. Gelatine, oil of theobroma, or gum arabic, is a suitable basis. The following formula is that used in Billroth's klinik :—

Iodoform (pulv.)		20.00 (3 v).
Gum Arabic Glycerini Amyli	āā	2.00 (3 ss).

The bacilli to be made of any required length or thickness. The above mixture contains 76 per cent. of iodoform. In introducing these into a sinus, care should be taken that there is no obstruction to the exit of the iodoform as the mass melts, otherwise symptoms of intoxication may arise. Bacilli of iodoform are also useful in cases of endometritis, and for rendering the secretions of the uterus antiseptic in cases of puerperal septicæmia. Dr. Alloway of this city has had an extended experience of the value of iodoform in these cases.

Iodoform is probably the most valuable agent that we possess for the treatment of the non-infecting syphilitic sore—the so-called soft chancre. The best method of using it is to spray an etherial solution on the sore ; the ether immediately evaporates and leaves behind an even layer of iodoform. One part of iodoform dissolves in seven of absolute ether. Under this mode of treatment, the non-infecting sore generally heals in ten days, while, if left to itself, it takes four or five weeks to do so.

The lymphatic glands in the groin are very apt to become inflamed and to suppurate as the result of the absorption of the poisonous material in the non-infecting sore. When the glands are in the first stage of inflammation, the best method of preventing suppuration is to inject into them about ten minims of a saturated etherial solution of iodoform. This should be repeated once daily until such time as there is distinct evidence of the inflammatory action abating. When suppuration has set in, the following is the best method of treating the case: first, by means of a free incision, the pus should be evacuated, then the infiltrated glandular texture should be all scraped away with a spoon. If the skin over the gland is of a purple color, it had best be removed also. This is best done with scissors. The cavity left is packed with iodoform gauze, over which should be placed several layers of the absorbent cotton wool, the whole being secured by a bandage. This may seem to be rather heroic and unnecessary treatment, but the success attending it is so marked and satisfactory that it should always be preferred to the ordinary, and at times very unsatisfactory, method of treatment. The great point in its favor is, that it does away with all possibility of the infecting matter contaminating the surrounding soft structures, and thus giving rise to extensive sloughing. Since this method of treatment has come into use in Neumann's klinik, the above untoward results have never been seen.

It has recently been recommended to use iodoform bacilli in the early stage of gonorrhœa. Watson Cheyne, who introduced this practice, says that he has had good results from it. In place of a gonorrhœa running a course of from four to six weeks, as it usually does, he maintains that if the case is seen early, the use of one or two iodoform rods will abort it. The iodoform is supposed to act by preventing the development of the micro-organisms which are the cause of the disease. This is a very plausible—even a very probable theory of the mode of action. If it was altogether true, however, we would expect that in practice it would always, or nearly always, succeed. Unfortunately, however, the iodoform treatment of early gonorrhœa does not, except, perhaps, in a very few cases, prevent the disease

running its usual four to six weeks course. Although it does not abort the disease, it exerts some influence over it—influence enough to make us employ it in suitable cases. I have seen several cases treated by this method, but in none of them was the disease aborted; in nearly all the cases, however, there was no doubt but that it had the effect of making the disease much milder. The following is the formula recommended by Cheyne:

Iodoform (pulv.)	- -	grs. 5.
Oil of Eucalyptus,	- -	♏ 1.
Oil of Theobroma,	- -	grs. 35.

To make one bougie of four inches.

Having dipped the bougie in oil, preferably in a mixture of equal parts of eucalyptus and castor oil, or in carbolic oil (1 in 20), the patient, after emptying his bladder, is laid on his back and the bougie introduced into the urethra, and forced up, if possible, half an inch beyond the meatus with a probe or pencil. To absorb the discharge, a pad of boracic lint is applied over the orifice, and retained in position, if the patient can do so, by drawing the foreskin over it; outside, a large piece of gutta percha tissue, with a strip of isinglass plaster, is used to keep the whole in position. The patient should, if possible, not urinate for five or six hours. On removing the pad, two syringefuls of a sulpho-carbolate of zinc solution (2 grs. to ʒ i) are injected. If the case is a very acute one, another bacillus should be introduced; afterwards the sulpho-carbolate injection should be used six or seven times a day for three or four days. When the acute symptoms have subsided, any remaining discharge may be treated by sulphate of zinc or alum injections. The rapidity of cure is much aided by administering a purge first and keeping the bowels open by giving an occasional saline. This form of treatment may be used at any stage of the disease, but it is most serviceable during the acute stage. If it fails to do any good, it will not do any harm.

Iodoform is a very useful agent in cases of cancer of the uterus, vagina, rectum, &c. Of course it is only a palliative, but it is a very valuable palliative. It relieves the terrible pains present in these distressing cases, and it also destroys the disagreeable fœtor of the discharges.

In putrefactive catarrh of the nose, iodoform sprayed (etherial solution), or applied in the form of an ointment mixed up with vaseline, is highly recommended. It is also a very valuable agent in the treatment of ulcers of the larynx, both simple and tuberculous. It is said to be capable of healing a tuberculous ulcer.

Iodoform is highly recommended for the dispersion of enlarged glands, especially scrofulous cervical glands. It is best employed in the form of iodoform-collodion, one part of iodoform to 15 of flexile collodion. This same formula is a good application for joints which are the seat of chronic inflammation.

Internal Uses.—The internal administration of iodoform is one of the methods recently adopted for the introduction of iodine into the system in cases of secondary and tertiary syphilis. It can be used in place of the iodide of potassium, when this salt disagrees. When practicable, the hypodermic injection of an etherial solution is the most efficient way of introducing it. Iodoform has been tried, and, it is alleged, with some success, in chronic pulmonary affections. In phthisis, it diminishes the expectoration and reduces the fever. It has also an undoubted influence in increasing the body weight.

UNTOWARD EFFECTS.

Cases of iodoform intoxication are not nearly as frequent now as they were shortly after its introduction into surgical practice. We are now better acquainted not only with the uses, but also with the abuses, of this valuable agent. It is very important that you should be able to recognize the symptoms of poisoning, because they may come on most unexpectedly. Sometimes they may make their appearance when only a very small quantity has been used, but this is not at all common. There are people who have an idiosyncrasy to its action, and in using it freely for the first time in a case, you should be on the alert for the first symptoms of its untoward action. It is impossible to lay down any rules as to the quantity that is safe to use, and the quantity that is dangerous to use. Some people bear large quantities with impunity, while others show signs of intoxication after comparatively small quantities. Very alarming symptoms have fol-

lowed the dusting of 90 grains into the wound for a breast removal. Death has followed the use of 35 grammes (ʒ ix). In Germany, where it has been very extensively used, some surgeons are constantly meeting with disagreeable, and at times dangerous, symptoms from its use, while others have never seen anything alarming. Mosetig-Moorhoff of Vienna has used it in 5,000 cases, and never saw any of its toxic effects. König, another German surgeon, has reported 15 cases of poisoning from it of various degrees of severity. There have been at least 15 cases of fatal poisoning from it in Germany alone ; the great majority of these cases occurred in the days before its occasional untoward effects were fully recognized, when it was not an uncommon practice to dust two or three ounces into a wound. Many cases are reported where as much as 6 ozs. have been dusted into the peritoneal cavity. Of course, there is no wonder that the use of such enormous quantities have led to fatal poisoning. The only wonder is that the fatal cases have been so few. Aged people and those with weak hearts stand its action badly, as might be expected from its well-marked cardiac depressant powers. Children are less liable to be poisoned by it than adults. Among the milder symptoms complained of are the following: Loss of appetite ; sleeplessness ; restlessness. A not infrequent complaint is that all articles of food taste as if they contained iodoform. When the iodoform dressings are removed, these symptoms very soon disappear.

There is a group of four serious symptoms due to iodoform intoxication. They are—1st, increased temperature ; 2nd, frequency of pulse ; 3rd, collapse ; and 4th, disturbance of the cerebral functions.

1. *Elevation of temperature.*—A temperature of 103°F. or 104°F. is one of the most frequent symptoms of profound iodoform intoxication. A temperature of 106°F. has been observed. This elevation of temperature may show itself a few hours after the first iodoform dressing, and it usually lasts for weeks. It is not uncommon for it to be present some days after the wound for which the dressing was applied has healed. The course of the fever is not unlike that of typhoid.

2. *Increased pulse rate.*—A pulse beating at the rate of 150 to 180 in the minutes has been observed in the majority of the fatal cases. When these two symptoms are combined, the case is, according to Schede, invariably fatal.

Cases of iodoform intoxication where either of the above symptoms are present are very liable to be mistaken for septicæmia. Now it is all important that this blunder should not be committed. The treatment of a case of septicæmia would naturally be the employment of more iodoform, and of course the consequences of this mode of procedure are plain to you all.

3. *Collapse.*—The symptoms of iodoform poisoning may suddenly manifest themselves in the form of collapse, from which there is no recovery. We know nothing about the nature of this form.

4. *Disturbance of the cerebral functions.*—This form of iodoform poisoning may resemble *meningitis* or *insanity*. The prominent symptoms of the meningeal form are vomiting, somnolence or deep coma, and contraction of the muscles. It is apparently peculiar to childhood. What now goes by the name of *iodoform insanity* has up to the present only been observed in women. There is great depression of spirits, with delusions, and a refusal to take food. Nearly all the cases of iodoform insanity reported have proved fatal. The following is an example of a fatal case of iodoform intoxication, where the prominent symptoms were those of the central nervous system: The patient was a woman, aged 30, on whom ovariotomy had been performed. 35 grammes (ʒ ix) of iodoform were dusted into the peritoneal cavity; then the abdominal wound was closed. All went well for two days. On the third day the patient was restless; her pulse was quick; she sang, chatted, and raged. She continued in this state for eight days, when she suddenly passed into a state of collapse and died. On post mortem, there was nothing found to account for her death. The great majority of cases of poisoning have occurred where it has been used in the treatment of wounds, and especially where large quantities have been dusted into the abdominal cavity. A few cases are reported where its toxic effects have been induced where it has been administered

internally. In these cases, the symptoms have been for the most part those of the central nervous system.

A case is reported where 75 grains were taken in pill form during the course of a week for ulceration of the throat. The patient, a woman, became sleepy; her gait was difficult and uncertain. In 24 hours, these symptoms were succeeded by a comatose state, which lasted for five days. In 14 days she completely recovered. Untoward symptoms are, however, extremely rare from the internal use of iodoform.

Although I have dwelt on the dangers sometimes attending the use of iodoform, I would not have you believe that it is an agent dangerous to use when it is given with caution. No doubt untoward symptoms may arise at times in persons very susceptible to its action, no matter what precautions you may use; but cases of this kind are extremely rare. The use of our most valuable medicinal agents is at times attended by untoward effects, but this is no reason why they should not be used. It should stimulate us to so employ them as to obtain all their good effects, and but little or none of their bad effects.

Post-mortem appearances found after Iodoform poisoning.—Fatty degeneration of the heart, kidneys and liver are almost constant phenomena in cases of poisoning where the symptoms have lasted over a week. In the few rapidly fatal cases reported, there was nothing distinctive found.

Treatment of Iodoform poisoning.—The first step consists, of course, in the withdrawal of the application. There is no chemical or physiological antidote for iodoform. The case must be treated on general principles. When the pulse is very weak and very rapid, stimulants are indicated. Elimination should be promoted by the use of large quantities of water. Although salt has the power of promoting the elimination of iodoform, its use is not advisable in cases of profound poisoning, as in some cases where it was given, it appeared to aggravate the symptoms. To prevent poisoning, the most important point to attend to is not to use the substance in large quantities, and especially not over a large extent of surface, particularly if there is much fatty tissue. It should not be dusted into a wound and then the parts

sutured closely. A wound treated with iodoform should not be bandaged tightly. There is less danger in using it in the form of gauze than in the form of powder. If symptoms of poisoning should arise, the gauze can be more readily and completely removed than the powdered iodoform.

To test for the products of iodoform in the urine, add a few drops of sulphuric and nitric acids, and afterwards a small quantity of chloroform. If iodine is present in any form, the mixture will assume a violet color.

Dose and mode of administration.—The dose of iodoform is from a half to three grains. It is best administered in the form of pill. The following is a suitable formula:—

Iodoform, - - - - 2 grains.
Sugar of Milk, - - 1 grain.
Glycerine of Tragacanth (q.s.) To make one pill. Dose, 1 to 3 daily.

The mode of using iodoform externally has already been fully considered when speaking of its uses in wounds, ulcers, &c. Several modes have been suggested of covering its characteristic odor, such as mixing it with balsam of Peru, oil of eucalyptus, otto of rose, tannic acid, coumarin, and Tonquin bean. Coumarin, a crystalline principle obtained from the Tonquin bean, is the most effectual of all these.

LITERATURE.

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Frey—Résultats du pansement à l'Iodoform (*Bull. de Therap.* 15 Avril, 1882.)

Ransome—The Influence of Iodoform on the Body-weight in Phthisis. (*Brit. Med. Jour.*, Jan. 5, '84.)

Cheyne—Abortive Treatment of Gonorrhœa (*Brit. Med. Jr.*, II., '80, 124.)

The best literature on the uses of iodoform in surgical practice is to be found in the weekly medical journals of Vienna of the present year. They contain a discussion on this agent which was commenced in one of the medical societies of that city over a year ago, and which is not yet finished. All the leading surgeons, physicians, gynæcologists, pathologists and physiologists of Vienna have taken a part in it. The best account of the untoward effects of the drug is that given by Schede of Hamburg. A synopsis of this will be found in the *Jahresbericht*.

QUARTERLY RETROSPECT OF OBSTETRICS AND GYNÆCOLOGY.

PREPARED BY WM. GARDNER, M.D.,

Professor of Gynecology, McGill University; Attending Physician to the University Dispensary for Diseases of Women; Physician to the Out-Patient Department, Montreal General Hospital.

Metria.—At the last meeting of the British Medical Association a discussion was held on this most important subject. The term metria is a valuable collective word to designate a number of affections, allied in some respects, but otherwise very dissimilar, which are commonly classed together under the title "Puerperal Fever." Dr. Lombe Atthill, whose mastership of the Dublin Rotunda Hospital recently expired, read a paper initiating the discussion. He said; "The pathology of metria is still far from being perfectly understood. Two facts alone are admitted by all who have studied the subject carefully, namely, first, that puerperal women are liable, under certain

circumstances, to be inoculated with septic matter conveyed to and deposited in the vagina by the hands of the attendants as well as by other agencies, when, either through carelessness or ignorance, proper precautions have not been taken to prevent such an occurrence, and that the disease produced by such inoculation is not an infrequent source of one of the forms of metria; secondly, that puerperal women may be self-inoculated by poisonous matter originating within their own bodies, from the decomposition of blood-clots formed within the uterus after parturition, or of portions of membranes or placenta which have been retained in utero. The only difference of opinion on this point being that Dr. Matthews Duncan and others term the disease produced in the latter way "Sapræmia," that is, resulting from the absorption of putrid matter, thus distinguishing it from septicæmia, or the disease produced by "organisms which, when conveyed to the blood, multiply indefinitely in it," while those which are the product of putrefaction "do not survive, far less grow, therein." (Dr. Matthews Duncan on Puerperal Fever, *Lancet*, Nov. 6th, 1880.)

He believes that poisoning in one of these two ways causes the vast majority of cases of so-called puerperal fever in private and hospital practice, that they are preventible, and that perfect cleanliness of hands, instruments, syringes, napkins, bed-linen, &c., will prevent the spread of the disease; that it is conveyed by local contact of infectious matter with absorbing surfaces of the genital tract and not by the medium of the air breathed by the patient.

Thorough cleanliness and antiseptic precautions will prevent the access of poison by the attendants. The author believes further that it is possible to prevent self-infection in a healthy woman by securing good permanent contraction of the uterus, and by washing out its cavity with disinfectant fluid when there is reason to suspect that it contains clot, &c. To secure contraction he makes it a practice to put all patients in whom the uterus is lax on ergot for a week. He believes the relaxed condition of the uterus to be one of the causes of the frequent occurrence of septicæmia in unmarried women. Mortality in

them from this condition is very great, and he believes that their great mental distress prevents recuperative processes in the uterus. He believes that in these latter cases antiseptic precautions cannot always prevent their occurrence, or any treatment that he knows of always stay their progress.

Besides the form of non-preventible self-infection from the placental site of the ill-contracted uterus just mentioned, Dr. Atthill believes in the existence of an epidemic highly infectious form, which spreads by the same means as ordinary epidemics do. He related a most interesting account of an outbreak of epidemic puerperal fever during the last six months of his mastership of the Rotunda. These latter outbreaks he is strongly inclined to believe are due to the introduction of the poison of some ordinary zymotic disease into the system of a puerperal patient, the symptoms being under such circumstances by this peculiar state of the system and of the blood totally different from those occurring in septicæmia. In illustration of this he further related the case in which a woman in labor, with erysipelas of the head and face, was unavoidably detained only a few hours in the hospital, but though her stay was so short several patients were attacked with puerperal fever and one died.

Dr. Thorburn, Professor of Obstetric Medicine in Owens College, Manchester, also read a paper, in which he discussed mainly three moot points: 1. The position of the zymotic diseases as a frequent cause of metria. 2. The difficulty in including epidemic "puerperal fever" in the same kind of classification as the more sporadic forms. 3. The advisability of adopting the term metria and abandoning altogether the term puerperal fever. On the first point he said, "as regards the share taken by the zymotic diseases in the production of symptoms wholly characteristic of the puerperal state, it is by the great majority admitted as an undoubted fact that in some way the poisons of scarlatina, erysipelas or typhoid fever may sometimes cause in the puerpera symptoms scarcely distinguishable from puerperal fever. On the one hand every obstetric practitioner has seen cases of typical and even mild scarlatina run-

ning their course unaffected in any way by the existence of the puerperal state, and on the other hand, who has not seen cases of puerperal fever, if there ever were such a thing, in its most typical and fatal form, where the sudden rigors, intense tympanites, high temperature, facial expression and rapid death, with or without colliquative sweating and diarrhœa were our only guides to diagnosis, while the subsequent clear proof of scarlatinal infection of the patient, or the handing on of it to nurses and relatives, or even, more rarely, the occurrence of a specific rash in the hour of death, have clearly stamped the disease as metria of scarlatinal origin. If puerperal fever and metria are to be used as collective terms, Prof. Thorburn does not see how, from a practical point of view, zymotic causation can be excluded. "A puerpera who has scarlatina which can be distinctly diagnosed, has scarlatina, and there is an end of it; but a woman who has the symptoms roughly described above has puerperal fever or metria, or whatever we are compelled to call it, and scarlatina or drain-poison, or erysipelas may for aught we know be its cause."

As regards the 2nd form, epidemic puerperal fever, Prof. Thorburn expresses his views as follows:—"Many who have adopted the modern views as to the ordinary sporadic cases of disease, hesitate to apply them to epidemics, where numerous cases are met with in rapid succession, or side by side, and when the cases are all of the same severe and fatal character. A further knowledge than we yet possess of how disease-germs propagate, or, in certain circumstances become hybrid, or how their activity becomes attenuated or intensified, will probably make this matter plain enough, but meanwhile, no one believes that sporadic hospital gangrene, or erysipelas, which can often in ordinary practice be traced to its real sources, was a different disease, a disease more really *sui generis*, when it attacked almost every patient at the seige of Lucknow, or in the trenches before Sebastopol. Precisely the same causes are—there is seldom only one cause at work; and if they occasionally produce an epidemic with remarkable uniformity and severity of symptoms, it is exactly analagous to what occasionally happens

in a lying-in-hospital, or, more rarely, in individual practice. From this point of view, and it surely cannot, nowadays, be considered a purely theoretical one, there would seem to be no difficulty in conceiving how that tolerably definite train of symptoms which ensues from the action of septic or zymotic germs in the hyperinotic blood of a puerpera may occasionally become stamped with the characters of absolute uniformity and epidemic virulence. The wave passes over as those of all epidemics do, and we return to sporadic cases."

Prof. Thorburn strongly advocates the use of the term metria in preference to puerperal fever, and suggested the giving forth by the Association of a collective recommendation to that effect.

Dr. Thos. More Madden announced his belief that puerperal fever is a specific infectious disease, distinct and peculiar to lying-in women, and that the variation in predominant symptoms is due to the same causes as produce such variations in scarlatina, measles, typhus, &c., namely, prevailing atmospheric epidemic constitution, general condition of the patient, intensity of septicæmic intoxication in each case, and a variety of other modifying circumstances.

In the matter of treatment, although admitting its general fatality, he claimed that we have improved considerably in our treatment of this disease, as shown by its result. He believed that in his own experience of twenty years he had seen a change in the type of prevailing epidemics of puerperal fever, requiring a modification of treatment. He well remembered often seeing the abdomen of the puerperal patient covered with a poultice of leeches as Dr. McClintock graphically described it. He had a lively recollection of the benefits derivable from such treatment in suitable cases. For the last fifteen years he, however, had never seen a case of puerperal fever in which any form of depletion could be borne. The disease had assumed an asthenic or typhoid type, appearing rather of septicæmic than inflammatory type. He believed in the efficacy of turpentine by mouth and enema, as well as by external application in those cases with or without marked uterine tenderness and abdominal

distension. The form of puerperal fever now most frequently met with is distinctly remittent in type. He had lately met with several cases of tertian character. In these forms our main reliance must be placed in quinine. This should be given in medium doses of three or four grains every three or four hours till cinchonism has been produced and maintained for some hours. All cases required the free use of nutriment and and stimulants. Whatever other treatment might be required, the use twice daily, of warm antiseptic intra-uterine and vaginal injections is essential in every case of puerperal septicæmia. At the same time he believed that they ought to be used with far more caution than is usual.

Mr. F. J. Bailey (Liverpool), Dr. Fancourt Barnes (London), Dr. Alderson (Hammersmith), Mr. J. E. Burton (Liverpool), Mr. Donovan (Whitwich), Dr. Alexander (Liverpool), Dr. Wynn Williams (London), Dr. A. D. Macdonald (Liverpool), Dr. Edis (London), Dr. Nesfield (Manchester), Dr. Wallace (Liverpool), Dr. G. Hewitt (London), and Mr. Wilson (Liverpool) took part in the discussions, but inasmuch as nothing novel or original occurred in their remarks, I refrain from reproducing their speeches.—(*Brit. Med. Journal, Aug. 11th*, 1883.)

Beitrag zur Therapie des Puerperal Fiebers, von Dr. H. Burckhardt, Bremen. *Zeitschrift für Geb. und Gyn.*, Bd. IX, Hft. 2.—Such is the title of a short contribution to the therapeutics of metria. The author reports a case. The patient, æt. 27, was a sufferer from frequent epistaxis, and was of great size during her third pregnancy. She was delivered by her family physician. The quantity of liquor amnii was very great. The loss of blood after labor was not great but relatively to the weakened condition of the woman by reason of the nose bleeding, it was enough to produce symptoms of acute anæmia, such as noises in the ears, faintings and chilliness. B. was called in on the 11th day. The temperature was then 40·3° C., pulse 130. The lochia consisted of a bloody offensive charge. The uterus was washed ont with a 5 per cent. carbolic solution, and an ice-bag applied to the abdomen. This was repeated next morning, and in the water as it flowed away

shreds of grayish black gangrenous matter appeared. A few hours later as the temperature remained high, B. decided to scrape out the uterus. This was accordingly done thoroughly with a curette, and a considerable quantity of the same stinking substance brought away. The uterus was washed out immediately afterwards. This was repeated twice daily. Two days later the temperature fell to nearly natural, and convalescence was speedily established. The author believes that the curetting of the uterus played a very important part in the treatment, and that in cases in which there is reason to believe that absorption of septic material from the interior of the uterus is going on, the curette ought to be used and followed by syringing out of the cavity and introduction of iodoform pencils.

The Treatment of Puerperal Septicæmia by the Intra-uterine Employment of Iodoform.—Iodoform, so valuable in the treatment of wounds, appears from recent experiments and experience to be equally valuable in the after-treatment of the puerperium. Dr. T. J. Alloway, of this city, published in the number of this journal for April last, the abstract of a paper read at a meeting of the Montreal Medico-Chirurgical Society a short time previous. For details I must refer our readers to the paper, and will merely say that Dr. Alloway's method of employment of the drug is in the form of suppository made with cocoa butter by pressure, and that they are introduced within the uterus by a stilette sponge-tent introducer, Sims' speculum being used to expose the cervix uteri. Three cases successfully treated in this way are related. The temperature charts appended appear to indicate a very speedy result from the treatment. In the last number of the *Archiv fur Gynakologie*, appearing two or three months ago, is a paper, by Ehrendorfer, assistant at Prof. Späth's clinic, in Vienna, on the same subject. The writer does not seem to be aware of what has been done in this treatment on this side of the water; at all events he makes no mention of the matter. His experiments were begun in November, 1881. He employs gum arabic, starch and glycerine as the excipients for making the suppositories, and finds that the result is a more soluble suppository than one made of cocoa

butter. The following is the formula :—Iodoform powder, 20 grammes ; gum arabic, starch and glycerine, each 2 grammes. Make into three suppositories of the length of about 5 or 6 centimetres. The suppositories are passed into the uterus by means of a forceps. Abstracts of the history of 27 cases thus treated are appended. They were all complicated cases, cases in which experience shows the danger of septicæmia developing to be very great. Amongst them may be instanced forceps and version cases, craniotomy, decapitation, decomposing fœtus, adherent placenta, retention of secundines after abortion, producing septic endometritis, etc. Of the 27 cases, three died. One of these was a case of placenta retained for many hours before its forcible removal under chloroform. The second was a face-presentation with prolapse of the umbilical cord, a rupture of the cervix extending, as the autopsy proved, into the peritoneal cavity and leading to suppuration. The third was delivered by craniotomy. It was a difficult operation and lead to several fissures and rents of cervix and vagina. Death occurred nearly six weeks afterwards. At the autopsy suppuration of the vagina and and necrosis of the symphysis pubis and right sacro-iliac synchondrosis were found.

Both writers allude to the obvious advantages of this antiseptic over intra-uterine injections of carbolized water, &c. Those qualities of iodoform whereby it adheres to wounds, its insolubility, and its quality of slow vaporization whereby it continues to act for a long time render it most valuable, inasmuch as it renders unnecessary the frequent irritating disturbance of the parts, unavoidable in treatment by intra-uterine injections.

Hydrastis Canadensis (*Golden Seal*) *in Uterine Hemorrhage.*—Schatz of Rostock read a paper on the virtues of this remedy at the last meeting (Sept., 1883) of the German Society of Naturalists and Physicians, at Freiburg. The author remarked that operative gynecology has achieved such triumphs within the last ten or fifteen years that the medicinal treatment of uterine disease has suffered unmerited neglect. While he believes that there are many cases of uterine hemorrhage that will yield to no medicinal treatment, and absolutely indicate curetting or the

removal of the uterine appendages, he also believes that such operations are sometimes unnecessarily performed. He has recently been trying a fluid extract of hydrastis prepared by Parke, Davis & Co., of Detroit, U.S. His attention had been directed to it by American medical literature. The results have been most gratifying and astonishing. He has tried it in fifty cases, of which only two-thirds were cases well adapted for showing its effects. "Golden Seal" has a reputation as a remedy for affections of mucous membranes, and appears to act by exciting contraction of the arterioles. Congestion of the genital organs is lessened by the remedy, and it seems to act in a different manner to ergot. Thus, while in some respects their action is similar, in others it differs. The hydrastis checks cases of bleeding which are unrelieved or even aggravated by ergot. Such are many cases of myoma. The author believes that the action of hydrastis is purely on the vessels, while that of ergot is chiefly on the muscle of the uterus. Steady administration of the drug renders menstruation more normal, lessening pain and quantity of discharge, and approximating the interval to the norm. These effects he has noticed not only in menorrhagia and dysmenorrhœa without local disease, but also when these symptoms are due to structural diseases of the uterus and its surroundings. The dose prescribed by the author is 20 drops of the fluid extract in water four times a day for a week before and during the painful or profuse period. The only disagreeable symptoms noticed from the drug were once agitation, and once a condition of mental hebetude. Apart from these symptoms, only good results have been noticed. Appetite is often improved.

A brief report of cases selected from the author's note-book is appended. These consist of myomata, congestive dysmenorrhœa, bleeding from the virgin uterus, bleeding associated with chronic parametritis, bleeding from subinvolution, from metritis and endometritis, and climacteric bleeding. (*Archiv f. Gyn.*, Bd. 22, Hft. 1.)

The Technique of Intra-uterine Treatment.—This is the title of a paper by Bandl, read at the same meeting as the last paper

noticed. Before proceeding to the subject proper of the paper, the author says: "How shall we answer the question—Is intra-uterine treatment necessary?" In many cases bimanual examination is insufficient. It will assist very much in determining the existence of coarse lesions to draw gently the uterus downwards about two finger-breadths by tenaculum or forceps. This is not to be done if there are evidences of recent pelvic inflammation, or if there be resistance, or if it cause pain, or if there be tumors attached to the Fallopian tubes. The use of the sound is indispensable. When used while the uterus is thus drawn down it yields far more certain results in determining the condition of the uterine mucosa. The author claims that in this way the situation of catarrh of the uterus can be ascertained. If the cervix be thoroughly cleared of mucus, and if then, by the use of the sound, or by the gentle alternate closing and opening of the blades of the Ellinger dilator, mucus appears, then catarrh of the uterine body exists. This is much rarer than the same disease of the cervix. The exact situation of the catarrh is to be ascertained by pressure with the sound over each part of the endometrium, while the uterus is thus drawn down. In the normal condition of the membrane, not the slightest bleeding is produced by gentle to and fro friction with the sound. Bleeding then indicates a morbid condition of the membrane. In this way the cause of bleeding and, if a local one, its exact source, may be ascertained. Menorrhagia in the nulliparous patient is usually due to a general or constitutional cause. In the parous woman, to a local one.

The author's method of intra-uterine treatment is peculiar. He exposes the portio with either a common tubular speculum or a Sims' speculum. A tenaculum is then firmly fixed in the cervix. If this be carefully done, moderate traction being made, not a drop of blood appears. This is important when the vulnerability of the mucous membrane is to be tested. The tubular or Sims' speculum is then withdrawn, the tenaculum being still held *in situ*. Over it is then introduced a short tubular speculum, with its end obliquely cut off. The length of this speculum on its short side is about 7 centimetres; on its long aspect 9 centi-

metres. With the left index finger and thumb the tenaculum is held, while the ring finger of the same hand steadies the upper edge of the speculum. In this way the writer claims that the uterus can be held perfectly secure. Into the speculum may now be poured any suitable solution. If asepticism during operative procedures be the object, enough of a 5 per cent. carbolic acid solution to cover the cervix is poured in. Then with the right hand the sound, dilator, canula, curette or scarificator may easily be used. The author employs the curette for cases of menorrhagia occurring at varying intervals after labor or abortion. In this respect he agrees with most authorities in the use of this valuable instrument. He uses a small, dull curette about 4 millimetres in diameter. This can usually be employed without preliminary dilatation, although the latter procedure usually affords advantages. The subsequent use of perchloride of iron solution he has discontinued. For treatment of chronic, cervical or corporeal uterine catarrh, he employs a silver canula 4 to 6 millimetres in diameter, perforated at the sides and end. A ten per cent. solution of sulphate of copper is poured into the cylindrical speculum. Through the fluid a canula of size suited to the condition of the cervix is introduced within the uterine cavity, or only within the cervix. It is inserted and withdrawn slowly and repeatedly, so that the fluid may be thoroughly applied to the diseased surface. The application is repeated every second, third or fourth day. Schatz finds this remedy very valuable in the treatment of erosions and chronic catarrh of the cervix.—(*Archiv f. Gyn.*, Bd. 22, Hft. 1.)

Reviews and Notices of Books.

Treatment of Diseases of Infancy and Childhood. With over four hundred formulæ and prescriptions.—By CHARLES H. GOODWIN, M.D. New York: C. H. Goodwin, M.D.

During the past few years several books devoted entirely to special therapeutics have issued from the American press, giving under the heading of the special ailment the views of more eminent men, as to the indications to be followed, and the par-

ticular drugs that may be employed. There can be little question that such works, if carefully compiled, may prove of much service to the practitioner, who may desire to rapidly acquaint himself with the latest views on treatment in some special case. One of the latest of these is the above compilation on the diseases of infancy and childhood, giving the views of the several leading medical authorities of New York city and including many hospital formulæ. The list of diseases is extensive—the selections are, on the whole, carefully made—the general and special lines of treatment to be followed as ordered by each physician are well laid down—and several of their special formulæ are given. It seems a pity, however, that in a book of this sort more care is not taken to specify invariably for what age the prescription given may be suitable. Junior practitioners are often at a loss as to the proper dose for a child. To our own mind it seems that the size of the dose may often make the difference as to whether a medicine shall be of service or not. Some of the doses given seem very heroic—but on that matter each physician speaks for himself. Occasionally we think that a word of caution might be given, as for example, for use in tonsillitis, even in advanced childhood, although no age whatever is specified. Quiniæ sulph. gr. x. at bed time. Tr. acon. rad. Fleming's gtt. v-x as a dose to be repeated until dryness of the throat, nausea, and vomiting set in.

The Pathology and Treatment of Venereal Diseases. By FREEMAN J. BUMSTEAD, M.D., LL.D., late Professor of Venereal and Skin Diseases at the College of Physicians and Surgeons, New York, &c., and ROBERT W. TAYLOR, A.M., M.D., Professor of Venereal and Skin Diseases in the University of Vermont, &c., &c. Fifth edition, revised and re-written, with many additions by Dr. Taylor. With one hundred and thirty-nine woodcuts and thirteen chromo-litho graphic figures. Philadelphia: Henry C. Lea's, Son & Co.; Montreal: Dawson Bros.

This latest edition of the great classical work of Dr. Bumstead has been most carefully supervised by Dr. Taylor, and

numerous passages upon the most modern investigations upon syphilis are to be found. In the section of therapeutics there is a good deal of new matter. Perhaps the most important suggestion is that made concerning the employment of coca as an adjuvant during a mercurial course. It is considered to have an excellent effect in toning and stimulating the nutritious powers and the general system in such a way that mercury may be given in larger doses, or at any rate, used with freedom without producing that depression and deterioration of the general health which is often seen. Dr. Taylor says "The use of coca in syphilis, secondary to that of mercury and iodide of potassium, is attended with results that no other agent now known to us possesses." The subjects of inoculation of animals with syphilis and the bacillus-origin of the disease, which are at present attracting much attention, have been included in this edition, and a chapter on syphilis and marriage has been appended.

A Practical Treatise on the Medical and Surgcial uses of Electricity: including localized and general faradization, localized and central galvanization, Franklinization, electrolysis and galvano-cautery. By Geo. M. BEARD, M.A., M.D., Fellow of the New York Academy of Medicine, &c., and A. D. ROCKWELL, M A., M.D., Fellow of the New York Academy of Medicine, Electro-Therapeutists to the Women's Hospital of the State of New York, &c. Fourth edition. Edited by A. D. Rockwell, M.D. With nearly two hundred illustrations. New York: Wm. Wood & Co.

This department of therapeutics is well worthy of the attention it is now receiving. The two authors have both been enthusiasts on the subject and have done a great deal to redeem it from the imputation of being largely in the hands of the irregulars. Their work has been growing in size and completeness with each successive edition until it now assumes the form of a handsome volume of 760 pages. In the present edition the chief changes are two—the remodelling of the chap-

ter on Franklinic electricity, owing to the recent improvements in that form of application, and the observations upon the successful treatment of extra-uterine fœtation. The latter is a very important practical matter and deserves attention. We know of no manual on electricity so complete in all its details and containing so much and such varied information upon all matters more or less directly connected with it.

Chemistry—General, Medical and Pharmaceutical, including the Chemistry of the U.S. Pharmacopœia.—A manual of the general principles of the Science and their application in medicine and pharmacy. By JOHN ATTFIELD, F.R.S., M.A. and Ph. D. of the University of Tübingen; Professor of Practical Chemistry to the Pharmaceutical Society of Great Britain, &c., &c. Tenth edition, specially revised by the author for America. Philadelphia: Henry C. Lea's, Son & Co. Montreal: Dawson Bros.

It is only necessary to mention the fact of a new edition of this work having been prepared. It is so universally known and so generally admitted to be one of the best text-books of chemistry extant, that further comment is unnecessary.

A Manual of Pathology.—By JOSEPH COATES, M.D., Pathologist to the Western Infirmary and the Sick Children's Hospital, Glasgow; Examiner in Pathology in the University of Glasgow, &c. With three hundred and thirty-nine illustrations. Philadelphia: Henry C. Lea's, Son & Co. Montreal: Dawson Bros.

This is a large and comprehensive work on pathology, sufficiently extended to include as much as would be sought for even by an advanced student, and yet kept well within the limits of a useful text-book. It is devoted to both general pathology and pathological anatomy. From the author's evidently large and varied experience of the results of disease-processes he is able to furnish instructive illustrations on almost every subject. This, combined with the introduction of a large

number of original drawings (very well executed) produces a book which is certain to be well received, and one which is probably destined to become one of the best known of the advanced text-books of pathology.

Types of Insanity, an Illustrated Guide in the Physical Diagnosis of Mental Disease.—By ALLAN McLANE HAMILTON, M.D. New York: William Wood & Co.

This, the work of a noted specialist, consists of ten plates drawn from instantaneous photographs with a short letter press description. The plates represent types of the various well marked groups of the insame. The list is the following:—Idiocy, Imbecility, Melancholia, Attonita, Chronic Melancholia, Subacute Mania, Chronic Mania, Dementia (two plates) and General Paresis. Plate X is devoted to illustrations of Opheotonia. The so-called insane ear, a remarkable condition often, but not exclusively seen, in the insane. It has been variously described as a trophic disorder, or as a hematonia. It may arise from slight injury. At first the auricle is hot, engorged and inflamed. It usually goes on to suppuration, and when the pus is evacuated a shrivelled, deformed, often flattened auricle is left to tell the tale. The plates are most characteristic of the various phases of mental disease, and will prove of great value in the study of the physical diagnosis of insanity. We commend the work to lecturers on insanity and all others interested in the subject.

Books and Pamphlets Received.

ILLUSTRATED MEDICINE AND SURGERY. Edited by George Henry Fox and Frederic R. Sturgis. Vol. IV., No. 4. New York: G. B. Treat.

TRANSACTIONS OF THE AMERICAN SURGICAL ASSOCIATION. Vol. I. Edited by J. Ewing Mears, M.D. Philadelphia: Presley Blakiston, Son & Co.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, December 28th, 1883.

T. A. RODGER, M.D., PRESIDENT, IN THE CHAIR.

DR. WOOD read a paper on the use of ether in obstetrics. His remarks were founded upon twenty-six cases where he had used ether instead of chloroform. Several cases were detailed at some length, and from the results of all he drew the following conclusions as to the relative merits, in his opinion, of ether and chloroform in obstetrics:—(1) Owing to the agreeable odor, early effects, and perfect safety of chloroform as an anodyne agent, it is without the least doubt the best agent to relieve pain and calm the nervous irritability incident to the first stage of labor. (2) This statement is generally true of the expulsive period, where complete abolition of pain is not the object of administration. (3) When, however, complete anæsthesia is required, as we find it necessary during the delivery of the child and for the performance of operations following or preceding delivery, then it is that chloroform largely loses its character as *the* obstetric anæsthetic, *par excellence*. Dr. Wood said that if considerations of safety must give way in general practice to greater convenience of administration, then in the operations of midwifery ether he thought must supplant chloroform. He alluded to the inflammable nature of ether and its explosive quality when mixed with a certain per centage of atmospheric air, as the operations of the obstetrician were generally at night; this was a serious objection to ether. Vomiting he thought as common with ether as chloroform.

DR. CAMPBELL said that during the past twenty years he had used anæsthetics very little; did not think it wise to give chloroform for hours, as some do; has noticed that the uterus does not regain its power as promptly when this is done. He saw an objection to ether in its smell and its being so irritating to the eyes. He believed the mental condition has much to do with the immunity from deaths with chloroform at this time.

The woman approaches the time for delivery without fear, knowing so many of her friends have safely passed over this trouble, whereas the person to be operated on by the surgeon has a dread often for a long time before.

DR. REED remarked that if there were no deaths recorded from chloroform during labor, then chloroform must be better than ether, as it has all the advantages without the objections. The statistics stood thus with regard to mortality—chloroform 1 in 3 thousand, ether 1 in 30 thousand, and gas 1 in 50 thousand.

DR. SMITH believes in easing a woman as much as possible, and has used and will use even for hours, if necessary, an anæsthetic composed of alcohol one, chloroform two, and ether three parts; had never seen flooding follow its use, and felt safe to allow a nurse to give it.

DR. TRENHOLME only used chloroform during labor. With regard to the use of anæsthetics during labor, he is now more opposed than ever. When called to a woman, and finding the first pains irritable and the os thick and firm, instead of using an anæsthetic for hours he administers 45 minims of laudanum; this gives ease from pains, and they do not recur for a week or even a month, as often these are cases of false pains. Was sent for by a woman who said she had come to full term, but on examining found the above conditions present, gave her 45 m. laudanum; pains did not return for a month, when found her as before; gave another 45 m. laudanum—she went on for another month, when he was sent for again, and as the indications were present, wanted to give another dose, but the woman said she had carried the child for eleven months, and would not carry it a year for anyone. She was delivered two or three days later. He said that very tedious long labors left the woman more prone to post-partum hemorrhage, and remarked that the heart was more fatty during gestation, which would look as if anæsthetics ought to be dangerous in obstetrics.

DR. H. HOWARD said that in his younger days anæsthetics were not known, and of course not used in midwifery cases, but

that in Ireland the pains of labor were often lessened by taking a good dose of whiskey punch; he never saw harm come from it.

DR. CAMPBELL thought that Dr. Reed's statistics were not strictly true, as he believed there were cases in Montreal where the woman died from flooding due partly to the chloroform used.

DR. RODGER had used anæsthetics largely always; used chloroform till within a few years, and had seen post-partum hemorrhage follow its use. Now uses ether, but finds it not so useful as chloroform for irritable subjects in the first stages; but for such cases he now gives a good dose of chloral. The great advantage ether has over chloroform is that you can dispense with an assistant in an instrument case, and feel perfectly easy while the nurse is giving the ether. In an instrument case before giving either anæsthetic he gives a dose of ergot to ensure good contraction.

DR. WOOD asked if any of the members had noticed whether their epileptics had anæsthetic spots.

DR. H. HOWARD said that nearly all the epileptics with mania have anæsthetic areas over the body or limbs.

Mastitis treated with Ice.—DR. CAMPBELL mentioned a case of inflamed breast apparently on the way to suppuration, and beginning in the usual way with sore nipples, which he was treating with applications of ice. The breast, which was very much enlarged, is now terminating by resolution, and is only one-half its former size.

DR. TRENHOLME said this was an old treatment; that in most cases the inflammation begins in the lacteal sacs and that each opens at the nipple. Hot applications congest and increase the danger of its spreading to other cotyledons, but that ice isolates the inflammation.

DR. CAMPBELL related a case where he had confined a woman and left her well; in three weeks he was sent for, as the baby was vomiting pus. On squeezing, pure pus came out of both nipples. The breasts were poulticed, and in 36 hours they looked like two bags of matter and discharged enormous quantities. He confined this same person lately, and now she nurses well from both breasts.

DR. TRENHOLME reported that one of his cases of removal of both ovaries and tubes, operated on three and a half months ago, was now able to enjoy life thoroughly; she skates, and recently had walked seven miles.

Stated Meeting, Jan. 11th, 1884.

T. A. RODGER, M.D., PRESIDENT, IN THE CHAIR.

Aneurism of Aorta—Rupture into left Bronchus.—DR. OSLER showed the specimen which was taken from a man aged about 50, who was admitted to hospital with shortness of breath, due apparently to bronchitis and emphysema. Attention was not particularly drawn to his condition. After a residence of three or four days in hospital, profuse hæmorrhage took place from the lungs and proved rapidly fatal.

The autopsy revealed the large aneurism of the ascending arch here shown. It projected beneath the sternum, the manubrium of which was eroded. Firm laminæ of fibrin occupied four-fifths of the sac. From the posterior wall of the transverse part of the arch two smaller sacs projected, the size of large walnuts; one of these had perforated the left bronchus and induced the fatal hæmorrhage. The heart was not hypertrophied. Aortic valves healthy. Interior of aorta atheromatous.

Aortic, Mitral and Tricuspid Valve Disease.—The heart showed extreme button-hole contraction of the mitral orifice with great thickening and induration of the mitral segments, adhesion of the aortic semilunar curtains with sclerosis, and great narrowing of the orifice and fusion, and thickening of the tricuspid valves, so that the orifice barely admitted the thumb. There was considerable hypertrophy of all the chambers, particularly the right ventricle. The patient, a woman, aged about 35, was brought to hospital with general anasarca and extreme dyspnœa, and died in 48 hours. No satisfactory history could be obtained, as she was a stranger, but she had had several previous attacks of dropsy.

Non-valvular Dilatation and Hypertrophy of the Heart.—DR. ROSS gave the following short history of the case: This

man, aged 48, had been under his care in the hospital for the past two years on and off, suffering from anasarca and at times with fluid in the pleura. He had a soft blowing mitral regurgitant murmur from his first admission; later on hypertrophy became evident, digitalis always relieved him. Two months ago he returned to the hospital and went through the usual stages of advanced mitral disease. He never had rheumatism or any of the usual causes of heart disease excepting that he was very intemperate.

Autopsy, by Dr. Osler.—A couple of quarts of serum in peritoneum, two or three pints in each pleura, and several ounces in the pericardium. Heart hypertrophied and dilated; thick yellow clots in right chambers. Weight of organ, 610 grammes. Valves normal; aortic segments competent; mitral segments a trifle thickened at edges; no vegetations. Mitral orifice over six inches in circumference; tricuspid orifice nearly seven. The chambers were much dilated, and there was moderate hypertrophy of the walls. Muscle of fair color. Apices of papillary muscles fibroid. Aorta smooth. Coronary arteries not atheromatous. Lungs showed moderate emphysema at anterior margins; general brown induration; a large infarct at base of right lung. No pleural adhesions. Cyanotic induration of spleen, which was double the normal size. Kidneys slightly enlarged, coarse and hard; three healing infarcts in the left. Catarrh of stomach and bowels. Liver undersized, a little granular in the surface, hard and firm, and in early stages of cirrhosis.

DR. OSLER remarked that this was the fifth or sixth case of the so-called idiopathic hypertrophy and dilatation of the heart which he had dissected. The question of ætiology was interesting and not yet settled. Most of these cases are in large powerfully built men accustomed to heavy muscular exertion, and Abbott, Myers, Leitz and others have regarded this as the chief factor. The condition of irritable heart described by Dacosta in young recruits may be supposed to be the initial stage of the process, although in the majority of instances the condition is transient. One point in connection with the etio-

logy must not be lost sight of, viz.: that in the great proportion of these cases the patients were hard drinkers, and how much the alcohol has had to do with the production of the disease is hard to say.

DR. TRENHOLME asked if the condition of his liver would throw light on the primary cause. DR. OSLER, in reply, said he thought not, as it was not much diseased.

DR. KENNEDY said he knew of two somewhat similar cases. One was that of an athlete who has a mitral murmur, and whom he believes will develop, later on, symptoms like those just related by Dr. Ross. The second case was a young man who had sent for him, as he was suffering from weakness and sickness of the stomach. On examination, a soft mitral murmur was discovered. This young fellow, the day before, had gone for a very long snow-shoe tramp. Dr. Kennedy said we might expect to see similar cases more frequently, as snow-shoeing was becoming so fashionable.

DR. DOUGLAS had seen many cases of irritable heart in the army, but they never led to a post-mortem, as they would always be invalided. He said that Dr. Myers attributed heart trouble in soldiers to the pressure of the hook of the tunic on the vessels of the neck, increasing the labor of the heart, and producing palpitation.

DR. CAMPBELL said that cabmen, who at times have such heavy lifts, are prone to heart irritation. He knew of one well marked case. Has seen two or three cases in young men who, from over exertion at playing lacrosse, suffered from symptoms similar to those in Dr. Kennedy's cases. He (Dr. Campbell) had lately been examining a lot of young men about to enlist, and noticed that most of them came from occupations requiring very little muscle or heart work, as shoe and cigar makers.

DR. BULLER called attention to Dr. Richardson's experiments with men working with and without alcohol. Whilst abstaining they did a certain amount of work with ease; the same men, allowed alcohol and doing the same work, suffered from palpitation and shortness of breath.

Pneumo-enteritis of the Hog.—Dr. Osler showed the colon from a case of this disease, known better by the names of hog cholera and pig-typhoid. A local outbreak in Hochelaga a few weeks ago furnished an opportunity of getting some interesting specimens. The disease is highly contagious, and the ravages in the United States probably exceed that of any other animal plague. The lesions are in the lungs and bowels—most commonly the latter, but the former may alone be involved. The specimen exhibited was a very typical example of the disease in the colon, the mucous membrane of which was converted into a thick greyish-yellow substance, owing to a sort of diphtheritic infiltration.

Dr. Alloway exhibited a *Fleshmole Placenta*, in the amniotic sac of which he found a small embryo (exhibited) mummified, which appeared to have been blighted at about the fifth or sixth week. The mole itself represented a mass about the size of a normal placenta at the fifth month. It had undergone fatty degeneration; its amniotic sac was filled with a dark-colored blood-clot, and contained the above-mentioned embryo. The history of the case was as follows: The patient, a young woman in her third pregnancy, had menstruated last in January, 1883. In March (two months afterwards), she received a severe fright, and had a slight flow of blood. From this occurrence she had no more discharge until the expulsion of a mole on 13th December following. During the months of February, March and April she had all the early symptoms of pregnancy; had noticed considerable increase in size, which continued until about June or July. She remained stationary in this respect for a short time, and towards the latter part she noticed herself reducing in size and the vagina giving exit to a muddy-brownish discharge (non-offensive). Dr. Alloway alluded to the interesting way in which these moles occur, and gave Scanzoni's views as follows: "The ovum remains with the dead fœtus for a considerable time in the uterine cavity; the coagulum (utero-decidual) undergoes certain changes, and so gives rise to the formation known as a *fleshmole*. The effused blood (utero-decidual) becomes decolorized by rupture of the blood corpuscles and absorption of their coloring

matter. The fibrin, Scanzoni supposes, becomes cellular tissue, and in this way is established a communication between the ovum and the uterine wall, which renders further development possible. The chief seat of this carneous degeneration is the decidua-vera. The amnion undergoes little change, and may be found adhering to the inner surface of the chorion, containing within its cavity a quantity of bloody fluid, and in which will be found what remains of the embryo." Dr. Alloway said his specimen corresponded to the description of a mole as given by Scanzoni; that he was sure the patient had become pregnant in, or before, March (nine months ago), and that the embryo had been retained in the amniotic sac in its mummified condition during that period. Dr. A. was also of opinion that many such cases occurred, but the embryo, not having been looked for, escaped in the discharge, and was thought to have been absorbed.

Dr. Geo. Ross said he had failed many times to find the embryo in an early abortion and had no doubt but they are often dissolved in utero.

Dr. Kennedy said that if there was any separation from the uterine wall then the embryo was rapidly dissolved. Had a case where the embryo was perfect; left it in the amniotic sac over night, but by the morning it was entirely dissolved. He (Dr. K.) did not believe that Dr. Alloway's embryo had been in the uterus very long, certainly not anything like what Dr. A. seemed to think. She might possibly have had one or more miscarriages early, but from the size of this specimen did not believe it was more than five or six weeks old. The relatively large size of the placental mass was due to its continuing to grow after the death of the fœtus.

Dr. Trenholme agreed with Drs. Ross and Kennedy.

Dr. Alloway, in reply, said he gave the Society the exact facts of the case, and wished the members to form their own opinion regarding the possibility of the embryo and membranous mass exhibited having been in the uterus for the length of time mentioned. In defence of the mass being what is known as a true mole, he gave Scanzoni's definition, which corresponded to his specimen. In reference to the black clot found in the

amniotic sac, it must have been recent, otherwise it would have undergone the changes explained by Scanzoni and which take place in extravasations in other parts of the body.

Dr. Alloway also exhibited a *small piece of decidua* (about one inch square), showing, on the inner side of it, a distinct lining of amnion. The history of the case from which he had removed the specimen with the dull curette was as follows:— Patient, a woman about 40 years of age, mother of 12 children, had been losing blood from the vagina for several days; had been taking medicine from a physician, and had had her vaginal passage plugged daily to arrest hemorrhage. She was found by Dr. A. in a dying condition; no pulse at wrist, surface completely blanched, and extremities cold. Could not obtain an answer to questions. Heart's action could be heard very faintly through chest walls. She had received the last rites of the church, and was, in fact, dying. Removed all the cloths and packing in vagina; felt a fringe-like substance high up above the internal os, but could not reach further with finger. Passed up curette and detached the piece of decidua, and withdrew it with forceps. Washed out parts with antiseptic solution. Patient could not swallow. Administered hypodermic of ether. Ordered beef-tea, egg and brandy rectal injection every two hours; heat to extremities and body generally. Patient improved by the morning, and gradually recovered life, but remains bloodless as when first seen, three weeks ago. Dr. Alloway said he adduced the case to show the great danger of following out rigidly the expectant plan of treatment in such cases. Efforts had evidently been made to remove the secundines with the finger, leaving behind the small portion exhibited, which was causing the hemorrhage. Those who opposed the curette were physicians who had never used the instrument, and had not convinced themselves of its perfect harmlessness and great value.

Dr. Trenholme said that a small piece of alum pushed into the os was what he found most useful for flooding in abortions.

Dr. Kennedy believed that interference was seldom needed; that where the ovum was not entirely separated, it was best to plug and give ergot. Had several times known flooding to have been produced by meddling.

DR. RODGER remarked that the physician first in charge of Dr. Alloway's case could not have plugged her properly, else she would not have been so low; believed the alum egg to be the most useful plug in such cases.

Elephantiasis of the Labia Minora and Clitoris—Operation—Death from Pyœmia three weeks later.—DR. GARDNER exhibited the specimen and gave the following particulars:—The patient, aged 45, came from the country with a history of syphilis for 13 or 14 years. Besides the above tumor, which was attached principally to the base of the clitoris, there was present stricture of the rectum and a recto-vaginal fistula. The orifice of the urethra was so large as to easily admit the finger into the bladder. Dr. G. amputated the tumor with a scalpel, dressing the wound with iodoform. The temperature rose next day and pyæmia developed; there was swelling and effusion into several of the joints, suppuration taking place in two of them. The pyæmia was caused probably by embolism of the veins of the part operated on, the fœtid ulcerations around supplying the septic matters. A post-mortem showed extensive ulceration of the rectum with a stricture only admitting a goose quill. A pus cavity was found in the left broad ligament, but there was no visceral suppuration. The tumor was about 4 or 5 inches long and nodulated.

DR. KENNEDY remarked that the operation was undoubtedly called for, but the result was unfortunate.

DR. ALLOWAY said he had a patient with a similar tumor which now measures 7 inches in length. It does not cause much trouble, being covered with good skin and kept wrapped in a napkin. It began when the lady was 10 years old and has been gradually increasing.

Extracts from British and Foreign Journals.

Unless otherwise stated the translations are made specially for this Journal.

The Therapeutic Use of Hot Water taken Internally.—This is the subject of a very interesting article by Dr. Ephraim Cutter in *Gaillard's Medical Journal.* The article starts out with a *resumé* of the history of this therapeutic measure. It originated in 1858 with Dr. James N. Salisbury, who undertook a series of extended experiments with a view to demonstrating the correctness of the theory on the strength of which the practice is based. Its object is to remove from the stomach the results of processes complicating digestion, but not necessarily a part of it, the principal of these processes being fermentation. The results of fermentation in the stomach are acetic, butyric, hydrosulphuric, lactic and saccharic acids, and sulphide of ammonium, vegetations and yeasts. The absorption of these gives rise to a variety of constitutional disturbances, which may even result in organic trouble, the seat of this organic trouble being the lungs, the liver and the kidneys, or other organs. It is probably generally well known, that Dr. Salisbury associates the absorption of these products of fermentation very directly with the causation of phthisis pulmonalis, and it is upon the assumption of this connection of cause and effect that he bases his well-known treatment of this disease by raw meat diet and copious washings of the stomach with hot water. Dr. Cutter is an enthusiastic disciple of Dr. Salisbury, and has done probably more than Dr. Salisbury himself to familiarize the profession with the latter's peculiar views and practices. The article gives explicit directions for the carrying out of this hot water treatment.

1. The water must be hot—not cold or lukewarm. The reasons for this are principally that cold water depresses, and that lukewarm water excites vomiting. By hot water is meant a temperature of 110° to 150° Fahrenheit, such as is commonly liked in the use of tea and coffee.

2. As to the quantity of water: The commencing amount

should not be less than half a pint, which amount must be gradually increased with the capacity of the patient, until the specific gravity of the urine stands at 1015 to 1020, the best standard of health. If on examination of the urine the specific gravity stands at 1030 more hot water should be drunk. On the other hand, should it fall to 1010, the amount should be decreased.

3. The time for taking hot water is an hour or two before each meal and half an hour before retiring.

4. The water should not be drunk too fast. It should rather be sipped, so that the stomach may not be so rapidly distended as to make it feel uncomfortable.

5. The length of time during which this hot water treatment should be continued is six months, this time being usually required to thoroughly wash out the liver and the intestines.

6. Should it be desired to add to the palatability of the hot water it may be medicated with clover blossom, tea, ginger, lemon juice, sage, salt, and even occasionally sulphate of magnesia. Where the thirst is intense a pinch of chloride of calcium or nitrate of potash may be added.

7. The amount of liquid to be drunk at a meal should not exceed eight ounces. This amount should not be exceeded, in order that the gastric juice may not be unduly diluted, or that the contents of the stomach may not be prematurely washed out.

It is claimed that under this treatment the fæces become black, the discoloration being due to the washing of the bile down its normal channel. While this blackness may last for more than six months the fœtid odor of ordinary fæces is abated and the smell approximates that of the fæces of healthy sucking infants. The urine becomes as clear as champagne, free from deposit on cooling and free from odor. The various secreting organs are said to improve as to their functions and a general feeling of well-being takes possession of the hitherto overladen and consequently inactive body.

The following is a summary of the general conclusions on the therapeutical drinking of hot water as given by Dr. Cutter. He

claims it to be the foundation for all treatment of chronic diseases. It excites downward peristalsis. It relieves spasm or colic of the bowels by applying the relaxing influence of heat inside the alimentary canal, just as heat applied outside the abdomen relieves. It dilutes the ropy secretions of the whole body and renders them less adhesive, sticky and tenacious. It is an inside bath. It dissolves the abnormal crystallized substances that may be in the blood and urine. It washes down the bile, mucus, yeast and waste, and thus leaves the stomach fresh and clean for the function of digestion. It promotes elimination everywhere.

It is necessary in conducting this treatment that the stomach should be rid of the hot water before meals, and this for reasons which are too obvious to require mention.

While we think it possible that Dr. Cutter has attached undue value to this means of cure, we cannot dispute the fact that the number of cases to which it is applicable is great. We should think it peculiarly applicable in the case of those who habitually gorge themselves, and whose systems are always overloaded with matter which the emunctory organs, constantly overtaxed, are unable to eliminate from the system. The thorough washing out which copious draughts of hot water would favor must be very beneficial in cases of this kind.—*Therapeutic Gazette.*

Serpent Venom as a Remedial Agent in Tetanus.—Dr. A. O. Ameden, of Glens Falls, N. Y., has experimented with the venom of a rattlesnake in a case of traumatic tetanus (*Medical News*) with most satisfactory results. Marking the contrast between the appearance of tetanus and that of snake-poisoning; in the one, the extreme rigidity and spasm of nearly the entire voluntary muscular system, and, in the other, a paralysis of both involuntary and voluntary muscles, the poisons were considered so obviously antagonistic that the doctor was induced to try the experiment. Having a case of tetanus in practice, and having obtained venom fresh from the fangs of the rattlesnake with a moistened point

of a hypodermic syringe, the poison was inserted beneath the cuticle in the upper dorsal region near the spine. Symptoms of snake-poisoning rapidly followed, with a decided amelioration of the tetanic spasm and rigidity, which entirely ceased at the end of ten hours, and the patient enjoyed a quiet sleep of six hours' duration. Thirty hours after the insertion of the poison, however, rigidity with slight spasms again came on. A second introduction of the venom was made as before, and no further trouble with tetanus was experienced, and the patient made a fairly rapid recovery. But extreme prostration followed the last introduction of venom, which necessitated alcoholic stimulation. The doctor believes snake-poison can be used with comparative safety, and may yet prove to be a valuable remedial agent in tetanus.—*Md. Med. Jour.*

Infant Foods.—Dr. Albert R. Leeds thus concludes an article in *Med. and Surg. Reporter*: I have been frequently asked why I do not publish my own opinion as to the best of the various infant foods now in use. To do so would be very unwise for many reasons. But I have endeavored to do what I have regarded as of far more importance than this, which is to praise or blame just as the information afforded by physical and microscopic examinations and chemical analyses demanded, without partiality or bias, and to seek out and state the principles upon which, as it appeared to me, the dietetic value of these articles of infant food depended.

To summarize the points which I have endeavoured to establish:

1. Cow's is in no sense a substitute for woman's milk.

2. Attenuation with water alone is inadequate, and chemical metamorphosis, or, mechanically, the addition of some inert attenuant is required, in order to permit of the ready digestibility of cow's milk by infants.

The utility of manufactured infant's foods is to act as such attenuants, and as such they take the place of the simple barley and oatmeal water, the sugar, cream, baked cracker, arrowroot, etc., etc., used in former times.

4. The results of both chemical and physiological analysis are opposed to any but a sparing use of the preparations containing large percentages of starch.

5. It is eminently probable that besides acting as attenuants, the matters extracted in the preparation of barley and oatmeal water, and still more the soluble albuminoid extractives obtained at ordinary temperature (whereby coagulation is prevented), by Liebig's process, have a great value of their own. For this reason, instead of employing starch, gum, gelatine, sugar, etc., the use of natural cereal extractive. containing saccharine and gummy matters and soluble albuminoids as well, such as our great and inspired teacher Liebig himself advocated, is in accordance with the developments of science since his time.

6. The use of a food made up of equal parts of milk, cream, lime-water, and weak arrowroot water, as practiced for years by the late Dr. J. Forsyth Meigs, and recently advocated by his son, Dr. Arthur V. Meigs, is sustained by theory, analysis and practice. It provides for the increase of fat to an amount comparable to that contained in human milk. It adds alkali to permanent reaction, and to convert caseine into soluble albuminates, it adds a little bland attenuant. And if, in addition, the amount of milk-sugar were raised, and instead of arrowroot water, barley or oatmeal water were substituted, as the case demanded, it would approach, it appears to me, still more nearly to the conditions required.

7. The perfect solution of the present problem is to be found in the modification of cow's milk by chemical processes, so as to make it physiologically equivalent to human milk. The nature of these processes, and the results to be obtained, are at present so nearly wrought out, that there is good ground for believing that such a solution of this problem is not far distant in the future.

CANADA

Medical and Surgical Journal.

MONTREAL, FEBRUARY, 1884.

TYPHLITIS AND PERITYPHLITIS.

Inflammation of and about the cœcum—typhlitis and perityphlitis—are common affections to which the attention of the profession has not been sufficiently directed. Very few of the text-books treat of them with proper fullness, and a good deal of ignorance prevails on certain points of vital importance in diagnosis and treatment. A recent paper* received from Professor Pepper contains some useful information gleaned from his extensive experience. The great majority of cases of inflammation in the cœcal region begin in the bowel walls, either of cœcum or appendix. Extension to the loose tissue in the neighborhood is a secondary process which may or may not take place. Acute typhlitis is most commonly seen in connection with impaction of fæces or chronic constipation and is ushered in by pain in the bowels with fever. The abdomen is tender, particularly in the right iliac fossa, in which region palpation may reveal a more or less distinct tumor. In 17 out of 48 cases (recovering without abscess) noted by Dr. Pepper, a distinct tumor was present. Pain and the abdominal distension often prevent a satisfactory examination. The patient lies on his back or to the right side with the right leg flexed on the pelvis. Vomiting is a very constant symptom; it may be stercoraceous. Constipation is almost invariably present. In one case reported, the bowels were allowed to remain unopened for 13 days, and then a natural motion took place. This is one of the most difficult

* A contribution to the clinical study of Typhlitis and Perityphlitis. From Trans. State Society of Penn., 1882.

features to deal with, and the lesson enforced by such cases seems to be, that "so long as there are fever, local soreness and pain, it is better to limit our efforts to the relief of pain and inflammation, and to restrict nourishment to the narrowest limits." There may be a marked disparity between the temperature and the pulse, the latter being unnaturally slow. A point of importance which is especially dwelt upon is the liability to relapse. In some instances a series of successive attacks, five, eight, or even twelve in number have been observed. Several very interesting cases of this chronic or recurrent typhlitis are recorded in the paper. The dangers of this form are of course very great from the possibility of ulceration and perforation, or from chronic induration with thickening of the walls, and great contraction of the calibre of the bowel.

Inflammation about the cœcum—perityphlitis—may be induced by many causes, the chief of which is undoubtedly extension from an ordinary typhlitis. Perforation of the appendix, round ulcers of the cœcum and tubercular or cancerous ulcers cause some of the most formidable cases of this affection. Perityphlitis need not necessarily terminate in suppuration; in many, perhaps the majority of cases, resolution takes place. The formation of pus is usually indicated by an aggravation of the constitutional symptoms, by rigors and sweats and fever of a hectic type. The local symptoms will depend on the size and site of the abscess. If the pus has formed between the cœcum and the iliac fascia it will come forward and appear above Poupart's ligament and in the flank as a brawny, perhaps fluctuating swelling. Owing to the tenseness of the transversalis fascia it may be difficult to get fluctuation. The distended cœcum may give a resonant percussion note through the abscess, or the resonance may be caused by gas in the abscess cavity, owing to a communication with the bowel. In many cases the pus lies deep behind the upper part of the cœcum and the first part of the ascending colon, and the fullness and point of tenderness may be in the lumbar region between the last rib and the crest of the ilium. And again, the seat of the suppuration may be deeper and much less accessible,

particularly in those cases of perityphlitis from appendix disease. Here the site of the abscess will depend on the position of the appendix, whether curled up behind the cæcum or directly down on the pelvic wall, or passing out at right angles to the cœcum and adherent to the promontory of the sacrum. In each of these positions we have dissected abscesses in connection with perforation of the appendix. When suppuration is suspected, the question of surgical interference arises, and it is on this point that diffusion of existing knowledge is needed. After eight or twelve days, during which time every effort has been made to prevent suppuration, "if the general symptoms persist or grow aggravated, or still more, if they assume a hectic type, and if the local conditions remain the same, or still more, if increased prominence of the swelling, discoloration or œdema of the abdominal wall, or fluctuation becomes apparent, exploratory puncture or incision should certainly be made, to be followed by the complete operation as recommended by Parker, if the presence of pus be demonstrated." Statistics show the results to be very favorable: of 100 cases collected by Dr. Noyes, of Providence, the mortality was only 15. If left alone the chances of recovery are slight; the pus burrows in various directions, and there may be extensive erosion of the lumbar vertebræ and the ilium. Perforation of the skin may occur in the groin, in the lumbar region, or in the perineum, and the patient dies exhausted by the constant drain. If small, the abscess may burst externally and the patient recover, but as a rule cases of this kind do badly, worse even than when perforation and discharge into the bowel or bladder takes place. We have seen recovery in two cases of this kind. Quite recently we saw a gentleman who had had five attacks of cœcal inflammation, the last evidently perityphlitic, and the abscess had burst into the bowel. The recovery is complete with the exception of a remarkable and unusual sequence, chronic œdema of the right leg, due no doubt to cicatricial thickening about the veins.

THE LONDON (ONT.) HOSPITAL.—A new wing has been added and several citizens and doctors have furnished rooms in it. The staff has been reduced to six, viz., Drs. Edwards, McArthur, Wishart, Arnott, Waugh and McGuigan.

SALE OF POISONS.

We have often asked the question, whether the Pharmaceutical Association of the Province of Quebec has done all it might have done, even with the restricted powers given to it by the Pharmacy Act, to prevent the careless sale of dangerous poisons.

Take *Paris Green*, for instance. It is one of the most deadly poisons known, an aceto-arsenite of copper, and from 4 to 6 grains is a poisonous dose. This poison may be justly termed the fashionable poison of the day, especially in rural communities, and yet every country storekeeper weighs it on the same scales as tea and coffee with the greatest unconcern, and hands it out unlabelled to his customer. We know druggists who stupidly inveigh against the Pharmaceutical Association for permitting grocers to sell salts, senna, sulphur, and other simple drugs, and yet when the Association speaks of placing Paris Green on the poison schedule, thereby entailing a very little extra trouble on the licensed pharmacist, although necessarily increasing his sales, they simply oppose the motion by saying the grocers and general storekeepers won't permit it because their customers, the farmers, require Paris Green for agricultural purposes.

Now we are of opinion that "arsenic and its preparations," which is already on the poison schedule, clearly covers "Paris Green," and that any unlicensed person selling this poison is liable to be prosecuted according to law whenever the Council of the Association sees fit to do its duty.

Hellebore which is also a deadly poison, is not, we think, on the list. It certainly should be, and we cannot see that the farmer or market-gardener would be much inconvenienced by unqualified persons being prevented from selling it. Most farmers can find a drug store when they want one, and the more difficulty is placed in the way of obtaining these poisons the better it will be for the farming population generally.

Paregoric, we are glad to see, has been recently added to the schedule, and although some pharmacists will grumble a

little at the trouble of registering sales, we think it will act as a check on the wholesale use of it for infants. For legitimate purposes the public will experience no difficulty whatever in obtaining it. We have written in no unfriendly spirit and with the sole intention of strengthening the hands of those members of the council who are in favor of restricting the sale of dangerous drugs. We only wish we could assist them in curtailing the facilities with which the public can obtain such remedies as Godfrey's Cordial, Nurses' Treasure, Winslow's Soothing Syrup, &c. We presume if any of these remedies can be proved to contain any one of the poisons in the poison schedule that no one but a licentiate of pharmacy could legitimately sell them.

CONFERENCE CONCERNING THE PROVINCIAL MATRICULATION IN MEDICINE.

The examination of candidates for admission to the study of medicine has been, for the last seven years, confided to a special Board of Examiners, the College of Physicians and Surgeons of the Province leaving the matter entirely in the hands of these gentlemen and accepting their decision as final on the competency or incompetency of the candidates. The result has been that about one-third of the candidates have been refused each year. Complaints have naturally been very numerous on the part of the unsuccessful young men, some claiming that the examinations were too severe, others contending that they were asked questions on subjects with which they had not been made familiar.

In order to give justice to all, it was resolved at the half-yearly meeting of the College of Physicians and Surgeons, held in September last, to call together all the directors and principals of the different colleges, high schools and normal schools of the Province, to confer with the Board of Examiners and a committee of the physicians, and to adopt such improvements as might be deemed necessary. This meeting took place on the 24th ult. in the rooms of the Medico-Chirurgical Society. Nearly all the colleges and schools were represented. The examiners present were Messrs. H. A. Howe, LL.D., Rev. H. A. B. Verreault, LL.D.,

and Abbé J. C. K. Laflamme, S.T.D. The College of Physicians and Surgeons was represented by Drs. R. P. Howard, E. P. Lachapelle, F. W. Campbell, and Joseph Lanctôt.

The meeting was of rather an informal nature, and each of the gentlemen present freely expressed his views. After examinin the programmes prepared by the Board of Examiners, the meeting was unanimous in declaring that the examinations were not too severe, and that if any change should be made, it should certainly be in the direction of making them even more rigid. It was ascertained that the weak points generally with candidates were French and mathematics, and it was agreed to push the pupils of the different institutions on these branches.

A suggestion was made by the Rev. Mr. Hamel, that the examination for admission to the study of Law, Medicine, or Civil Engineering should be one and the same, under a single Boord of Examiners.

Some of the gentlemen present were also of opinion that the examination should take place during the summer holidays, so as not to disturb the pupils while at school.

—The appeal in the case of Prof. Donald McLean, of Ann Arbor, *v.* the Detroit *Evening News* for libel was before the Supreme Court last month, when a motion for rehearing was denied. A cheque for $20,000, the amount of the original verdict, has been lodged in the hands of a third party, but an injunction has been filed to prevent Dr. McLean using the cheque on the ground that the verdict was obtained through gross corruption in the jury room The Court has ordered Dr. McLean to show cause why the injunction should not be made perpetual.

—We have received the first number of a new quarterly journal, published in Boston, called the *International Review of Medical & Surgical Technics*, which is the official organ of the American Association of the Red Cross. The journal is a very creditable one, and profusely illustrated. It is "devoted chiefly to the description, illustration and discussion of instruments, appliances and methods of operation that have been recently devised is published." It is in no sense a trade journal, and is not devoted to the interest of any manufacturer of surgical instruments. The journal will prove of great service to surgeons, both general and special. We wish it every success.

Obituary.

JOHN REDDY, M.D.

It is with renewed regret that we are obliged to chronicle the decease of another of the well known medical men of Montreal, Dr. John Reddy.

Dr. Reddy was born on the 31st March, 1822, at Athlone, Co. Roscommon, Ireland. In accordance with the custom of that day, he was apprenticed to a local surgeon in the year 1839, and remained with him until 1842. In April, 1847, he appeared before the Royal College of Surgeons of Ireland, and received their License in April of that year. Owing to some demands which he considered unreasonable, he would not go up for the degree in Dublin, but preferred crossing to Glasgow, at which University he received the degree of M.D. in 1848. It was now the intention of Dr. Reddy to enter upon the career of an Army Surgeon, and he was actually gazetted to a commission in the line. His regiment was just at this time, however, ordered to the Gold Coast for service. The young surgeon believed that he had not been born only to fill a premature grave in that most unhealthy station and at once resigned. Dr. Reddy then for a short time held some dispensary appointments in Ireland and came to Canada in 1851. Through the influence of some friends in Montreal he had been appointed House Surgeon of the Montreal General Hospital, and immediately entered upon the duties of that office. He remained in the Hospital for three years, fulfilling the responsibilities of this position to the great satisfaction of the then medical officers, Drs. Crawford, Arnoldi, Jones, et. al. On leaving the Hospital, Dr. Reddy began private practice in the city.

The year 1854 will be remembered as the last during which a severe epidemic of Asiatic cholera swept over this country. Dr. Reddy at once devoted himself with unremitting attention to the care of the many sufferers who were falling on every hand. His unvarying kindness to his patients, his cheerful, warm-hearted Irish manners, his already considerable skill

and experience soon led to his finding himself surrounded by a large and daily increasing *clientele.*

For just thirty years Dr. Reddy continued to practise his profession in this city, his perseverance and assiduity knowing no rest, constantly and busily employed from morning till night and very often from night till morning, until last year, to the regret of his many friends, it was observed that his health was beginning to fail. He went to Europe for change of air and the much needed rest, but unfortunately no return to health was to come to him and he died in Dublin on the 23rd January, 1884.

Dr. Reddy held many offices of the highest trust and honor in this community. In 1856 he was appointed one of the attending physicians of the Montreal General Hospital, which post he held until he retired upon the Consulting Board, now three years ago. In 1856 he received the degree of M.D. *ad eundem* from McGill College, and for many years served as Representative Fellow in Medicine in the corporation of that University. He was a constant attendant at the meetings of the Medico-Chirurgical Society and was elected President. He was a long-service officer in the volunteer militia, having been Surgeon of the Montreal Garrison Artillery.

His was a quiet, unostentatious, busy, blameless life. His high moral character and strict professional integrity, his broad benevolence and universal goodness of heart, with kind and obliging manners, procured for Dr. Reddy the respect and esteem of all his professional friends and *confreres*, his numerous patients, and the general community. His memory will long be cherished and his character and good deeds held in warm remembrance.

ALEX. JAMIESON, B.A. (Queen's), M.D. (McGill, '77), of Kansas City, died a few weeks ago. Dr. Jamieson was a native of Lancaster, Ont., and after completing his college course at Queen's, came to McGill, where he distinguished himself as a very able student. Several years ago he moved to Kansas City, and had there succeeded in building up a good practice. He was President of the department of Chemistry and Pharmacy in the University of that city.

Personal.

J. S. Lathern, M.D. (McGill, '82), has settled in Halifax, N.S.

Alex. MacNeill, M.D. (McGill, '83), has settled in Kensington, P.E.I.

George Carruthers, M.D. (McGill, '83), L.R.C.P., Lond., has settled in Summerside, P.E.I.

Thomas Gray, M.D. (McGill, '79), late of Brigus, Nfld., has returned from Europe and settled at Paisley, Ont.

We are pleased to see that Dr. McMillan, of Alexandria, Glengarry, has been made a Dominion Senator.

Dr. Dowling, who was unseated a few months ago, has been re-elected to the local House from North Renfrew.

Dr. W. McE Scott, of Winnipeg, has been spending a few weeks in town with a patient with traumatic aneurism brought down for consultation.

Dr. Plummer, Professor of Anatony in the Cooper Medical College, San Francisco, and Registrar of the State Board, was in town on the 6th and 7th.

Dr. Holmes, of Brussels, has been elected Treasurer of Huron Co., Ont.; Dr. Falkner, of Sterling, Warden of Hastings, and Dr. Willoughby, of Colborne, Warden of Northumberland and Durham.

Hon. Dr. Ross, of Ste. Anne de la Parade, has undertaken the task of forming a new Ministry in this province. With eight or nine members of the Senate and House of Assembly and the Lieutenant-Governor and Premier, the profession in this province may be said to have a full share of parliamentary honors.

We had the pleasure of seeing the following medical men in town during carnival week:—Drs. J. M. Lefevbre and J. F. Jackson, Brockville; James Ross, Toronto; Digby and Philip, Brantford; Surgeon-Major Orwin, Halifax; Powell, Grant, Jr., and Small, Ottawa; E. W. Smith, West Meriden, Conn.; Scott, Hull; Walker, Dundas; Gibson and Cotton, Cowansville; Gibson, Jr., Durham.

COLLEGE OF PHYSICIANS AND SURGEONS OF THE PROVINCE OF QUEBEC.

Programme of Preliminary Examination for 1884-85-86.

OBLIGATORY SUBJECTS.

LATIN.—*Cæsar's Commentaries*, Book V.—*Virgil's Æneid*, Book V.—The *Odes of Horace*, Book I.

ENGLISH.—*Sprayue's* "*Six Selections from Washington Irving's Sketch Book.*"—A Play of *Shakespere's*, viz., "*The Tempest*," for 1884; *Richard III.*, for 1885, and "*The Midsummer Night's Dream*," for 1886.

FRENCH.—*Fénélon's* "*Aventures de Télémaque.*"—A French Play, viz., *Corneille's* "*Le Cid*," for 1884; *Molière's* "*Le Misanthrope*," for 1885, and *Racine's* "*Esther*," for 1886.

BELLES LETTRES.—*Principles* of the subject. History of the Literature of the age of *Pericles* in *Greece*, of *Augustus* in *Rome*, of *Elizabeth* in *England*, and *Louis XIV.* in *France*.

HISTORY.—*Outlines* of the History of *Greece* and *Rome*, with particular knowledge of *England*, *France* and *Canada*.

GEOGRAPHY.—*A general view*, with particular knowledge of *England*, *France* and *North America*.

ARITHMETIC.—Must include *Vulgar* and *Decimal Fractions*, *Simple* and *Compound Proportion*, *Interest* and *Percentages*, and *Square Root*.

ALGEBRA.—Must include *Fractions* and *Simultaneous Equations* of the First Degree.

GEOMETRY.—*Euclid* Books I., II., III., or the portion of plane Geometry covered by those Books. Also the measurement of the lines, surfaces and volumes, of regular geometrical figures.

OPTIONAL SUBJECTS.

GREEK.—*Xenophon's Anabasis*, Book I. — *Homer's Iliad*, Book I.

PHYSICS.— *Outlines* of the subject as in *Ganot's Physics*, translated by *Atkinson*.

PHILOSOPHY.—Elements of *Logic* and of *Moral Philosophy*, as in *Jevons Logic* and *Calderwood's Hand-book of Moral Philosophy*.

N.B.—A sound knowledge of the Grammar of the above Languages will be required. Failure in *Latin* or in *Arithmetic*, or in the *Mother Tongue*, may involve rejection of the Candidate. French-speaking Candidates may omit *Shakespeare*, but will be expected to translate into French, passages from *Washington Irving*, and answer questions of grammar and parsing. They will require to have a critical knowledge of the French Works above named. Similarly, English-speaking Candidates may omit *Corneille*, *Molière* and *Racine*, but will be expected to translate into English passages from the first half of "*Télémaque*," for 1884 and 1885, and from the second half, for 1886, and answer questions of grammar and parsing. They will be required to have a critical knowledge, grammatical and literary, of the English Works above named.

Bad writing will be visited with a reduction of 5 per cent. from the marks gained. Any Candidate detected in copying or in conniving at another's copying from him, or in using books or notes, will be immediately dismissed from the room.

TIME AND MARKS ALLOWED FOR EACH SUBJECT.

Latin	2 hours.	300	marks.
English	1½ "	150	"
French	1½ "	150	"
Belles-Lettres	1 "	100	"
History	1 "	100	"
Geography	1 "	100	"
Arithmetic	1½ "	150	"
Algebra	1½ "	150	"
Geometry	1½ "	150	"
Greek	1½ "	150	"
Physics	1½ "	150	"
Philosophy	1½ "	150	"
Marks attainable		1,500	

H. ASPINWALL HOWE, LL. D.,
H. A. B. VERREAU, LL.D.,
M. MILLER,
J. C. K. LAFLAMME, S. T. D.
} *Examiners.*

CANADA

MEDICAL & SURGICAL JOURNAL

MARCH, 1884.

Original Communications.

ON A CASE OF EMPYEMA.

By J. G. SCOTT, M.D., Hazeldean, Ontario.

(Read before the Ottawa Medico-Chirurgical Society.)

Mr. President and Gentlemen,—The case I am about to bring under the notice of this Association is, I think, of sufficient interest to warrant me in asking your attention for a short time.

Mrs. J—, aged 20 years, has been married for two years.

Family History—Tubercular history in her father's family, her aunt and grandfather having died of phthisis.

History—Never had any serious illness, but always robust and healthy up to April, 1882, six months after her marriage, when I attended her in a miscarriage, being about three months pregnant; the cause of such miscarriage I could not ascertain. She made a good recovery, nothing occurring to prolong her illness.

In the latter part of July of the same year she was again threatened with a miscarriage, but this time, fortunately, it was averted, but she lost considerably during the attack; however, she went on to full time, and was delivered of a fine, large, healthy-looking boy, Feb. 17th, 1883. Patient lives 10 miles from my office, and although engaged to attend her during her accouchement, I was unable to do so, and a neighboring physician was called in attendance. On the 4th of March, or fifteen days after labor, I was summoned in great haste to the case, when I elicited from her mother a full account of her accouchement and illness up to the time of my attendance. Labor pains came on

about 12 p.m., Feb. 16th, and she was delivered about 3 p.m., Feb. 17th, before the accoucheur arrived. The placenta being adherent, he removed it by manual interference. On the eleventh day she had chills, with headache, thirst and violent pains over the womb; the lochia, which had been scanty in amount, and very offensive, were suppressed, and the secretion of milk to the breasts was arrested. The baby was not applied to the breasts at all.

On examination, I found her with a temperature of 104⅘°F.; pulse 110, small and very weak; complexion sallow; features pinched; tongue dry and coated; partial delirium; abdomen soft; uterus enlarged and very painful on pressure. I washed out the womb with 1–40 carbolic acid, when some shreds came away; applied hot applications, and gave internally Quiniæ Sulph. grs. ii, Morphia Sulph. gr. ¼, to be repeated every three or four hours as required. Ordered liquid nutritious diet, with brandy.

I gave an unfavorable prognosis and left, to return March 6th, when I found her much more comfortable; temperature 100°F.; pulse 90, and much stronger. I now put her on calomel and opium, and requested to hear from her next day. Living so far away from the office, it was impossible for me to attend her daily. On March 7th, her husband reported that she was doing well. On the 9th, I found her temperature up to 103°F., pulse 120, weak and easily compressible, and delirious. I again washed out the womb, and some more shreds came away. I now put her on quinine and morphia again, with the same dietetic treatment. She improved rapidly, and on March 21st she had no pain, no tenderness over the womb, appetite pretty good, slept well, but the abdomen was slightly distended, and her temperature was 103$^{a^c}$F., pulse 90. I examined her lungs carefully, and there was absolutely nothing abnormal either on percussion or auscultation; her heart was also normal, but weak. I could not account for the rise in temperature and the frequency of the pulse, but I feared some unforeseen trouble was about to set in.

March 23rd.—I was requested to visit her immediately, which I did, and found that she had oppression of breathing,

pain in the side, short hacking cough, temperature 104°F., pulse 120, full and bounding. Percussion revealed wooden dullness from apex to base of left lung; normal note over right. I at once suspected pneumonia. Auscultation revealed no crepitation, no friction, no blowing-breathing, but a peculiar sound louder than normal vesicular murmur, but not so loud as bronchial breathing. Puerile breathing over right lung. There was no bulging of the intercostal spaces. I did not examine the two sides by comparative measurement with the tape-line. Apex beat of the heart was a little to the right of the sternum, and on this I rested my diagnosis of fluid in the left pleural cavity. I introduced a hypodermic needle in order to confirm my diagnosis and ascertain the character of the fluid, which I found to be serous. Not having an aspirator with me I returned home, secured one next day, and on the 25th returned, aspirated and drew off three quarts of serous fluid, which was streaked in some places with opalescent matter. She felt much relieved, respiration became more tranquil, the temperature fell, and the pulse became slower and not so full nor bounding, all of which we might expect after the removal of such a quantity of fluid. I then put on a fly-blister, painted the chest with a mixture of iodine and belladonna, and gave internally alterative and tonic treatment, and ordered poultices to be applied after the blister had risen.

During my subsequent visits, I found that the fluid was again accumulating; that the heart, which had assumed its normal position, was again being pushed over to the right; that the temperature had risen; that the pulse was again accelerated, full and bounding; that respiration was becoming more and more labored, and that she was restless and very irritable.

April 3rd (eight days after I had aspirated).—I called my friend and preceptor, Dr. Church, in consultation, when we decided to aspirate, which we did under chloroform, and removed over two quarts of opalescent matter. But let me note here that when I introduced the needle of the aspirator (using the largest) no fluid escaped, so I withdrew it, ran the stilet through it, and discovered that the first matter that entered the needle was a

clot of pus, which clogged the needle and prevented any matter escaping. I then reintroduced it, with the above result. Again the fluid accumulated; she became very irritable, appetite failed, refused both nourishment and medicine, objected to another operation, and said she would die in peace; and now, for the first time, a fistulous opening into the bronchi was established, and mouthfuls of greenish purulent matter were coughed up, which was very fetid.

April 18th, or 15 days after the last operation.—I was summoned with the announcement that she was dying. When I reached the house she was in a state of furious delirium. Shortly after my arrival she calmed down, and I took her temperature, which was 105°F., pulse 140. In a few moments she again became furious, when I put her under the influence of chloroform and aspirated, this time drawing off over three quarts of purulent, greenish, very fetid matter—in fact so much so that the odor was almost intolerable. I found great difficulty in administering the anæsthetic on this occasion, as it seemed to induce coughing, and she would gulp up mouthfuls of matter that had entered the bronchi, and as I was alone, I had to attend to everything unaided. Having previously determined on introducing a drainage tube, I now decided to wait the result of the fistulous opening, hoping that the matter might be expectorated and a cure thus effected; but in this I was disappointed, as the pleural cavity again began to fill up.

During this time I myself became unwell, and my friend Dr. Small kindly visited the patient for me, and aspirated, removing 45 ozs. of matter of a similar nature to the last removed. Not being satisfied with the general results of drainage in empyema by means of rubber-tubing, knowing that it easily becomes blocked up, and that if there was much retraction of the chest, resection of a rib would be a necessity in order to drain, I hesitated before resorting to it. Being still unwell, and needing a few days' recreation, I visited Montreal, and while there, called on Dr. Ross, to whom I gave a brief history of the case, and solicited his advice, which he freely gave, and for which I am deeply indebted. The substance of that advice was: that I

should procure a silver drainage tube, such as they use of late in the Montreal General Hospital, and, with antiseptic precautions, introduce and drain the cavity. That advice I followed out to the letter, with the exception of the antiseptic precautions, and with what result you will presently hear.

July 14th.—I administered chloroform with difficulty, and with a scalpel made an opening in the intercostal space, below the inferior angle of the scapula, and introduced the tube, when over three quarts of very fetid matter escaped. She coughed considerably, and with each cough the matter was ejected to a distance of at least three feet through the tube. I gave a hypodermic of morphia, which allayed the cough and eased the patient. When fully recovered from under the influence of the anæsthetic, I had her assume the sitting posture, and then washed out the cavity with a warm solution of carbolic acid (1–40), and continued to do so until the fluid returned quite clear, being careful at the same time to have the air of the chamber both warm and moist. I then applied lint over the tube, followed by a layer of cotton batting, and over this a bandage to keep the dressing in place. Her usual weight had been 145 lbs., but now she scarcely turned the scales at 90 lbs. Next day I visited her, and washed out the cavity again, a good deal of matter having drained away. I instructed the nurse how to wash out the cavity and dress the side, insisting on her using the solution warm and repeating twice daily. When I returned in two days I found her cheerful and bright, and her temperature now for the first time during my attendance was below 100°F. Not nearly so much discharge. I washed out the cavity and dressed as before, this time using plain tepid water for the injection, and left instructions as before, but using tepid water now instead of the acid solution. I visited her tri-weekly, and each time found her improving rapidly, her temperature never going above 99°, and pulse never above 80. She weighed every week, and reported an increase each time. The discharge became less and less in amount, and on August 31st, or 48 days after the tube had been introduced, no matter appeared on the dressing, and on washing out the cavity, the fluid returned quite clear. I now

closed up the tube, and left it *in situ* until Sept. 9th, when I removed it, no matter having accumulated, and none appearing in the fluid injected. I now applied adhesive straps in such a way that the edges of the wound were brought into pretty close apposition, and then dressed with whiskey dressing; and on Sept. 18th the wound was completely healed, there was little or no retraction of the chest, and the lung had expanded fairly well.

She continued to gain in strength, and in the latter part of November she began to do her own housework, and continues to do so up to the present time. Her husband reported a few days ago that she never felt in better health, and that the only visible difference in the two sides is the scar left where the incision had been made, and that her menses had appeared regularly for the last two months.

In examining the reports of cases of empyema by different authors that I had at hand, I find in nearly every case that strict antiseptic precautions are advised. In the *Medical Times and Gazette* a case operated on by Dr. Goltdammer is mentioned, using antiseptic precautions, resulting in a perfect cure; and it goes on to say that a few years ago such a case would be considered miraculous, but now, thanks to the antiseptic method, we scarcely wonder at it. Dr. Cheadle, of St. Mary's Hospital, says that full antiseptic precautions in paracentesis and dressing afterwards had been disappointing. He says they were adopted in three cases, and all ended fatally. The same writer merely requires carbolized instruments and dressing of carbolized tow. In the case I have just reported, you see that no antiseptic precautions were used, and no case could have a more favorable termination; but from the result of one case alone we cannot draw definite conclusions, still it proves that antiseptic precautions are *not absolutely necessary* in order to insure success in *every case.*

In the rural districts it is almost, if not altogether, impracticable to follow out antiseptic treatment to the letter, for many of our patients reside miles away from our office, and to attend them daily during a long illness is impossible, and to have the nurse faithfully carry out such treatment in our absence is equally

impossible; besides, many of us have no spray-producers at all. I look on antiseptic surgery as the æsthetic treatment of the day, but not at all absolutely necessary, and that the *strict* Listerian routine practice will, in the near future, have lost many of its admirers. Dr. Campbell of New York arrived at the following conclusions in a report published in the *Lancet* for Jan., 1879: "That to operate early is absolutely necessary in order to insure a *possibility* of recovery. To make a free incision to insure thorough drainage. Not to allow the wound to close until the discharge ceases, and to keep the cavity cleansed and disinfected."

To operate early by making a single free incision I believe to be the most judicious treatment; say after having aspirated once or, at most, twice, the matter again accumulating. And if I had introduced the dainage-tube earlier in my case, I have no doubt but that I would have had a similar result at a proportionately earlier date. To *operate early*, though the better treatment, is not *absolutely necessary* for the *possibility* of recovery; but to keep the wound open until all discharge ceases I believe is.

I chose the intercostal space immediately below the angle of the scapula, as necrosis would less likely be produced in this position if much retraction of the chest occurred. Dr. Cheadle objects to this position, giving as his reason that there is often swelling, suppuration, and local abscesses due to injury of the muscles with the friction, heat and pressure caused by the patient lying on his back. None of these conditions occurred in my case, and I think such could be avoided by following the plan I adopted, viz., to inject slowly all the fluid the cavity will contain while the patient is in a sitting posture; allow it to remain there for a few moments, the patient changing position, and when you wish to empty it, let him lie on his back and immediately the fluid injected escapes through the drainage-tube; repeat until the fluid escapes quite clear. Dress the side, and the patient can now assume any position he may please, and thus obviate the necessity of constantly lying on the back in order to establish free drainage, for when this is repeated twice daily very little matter can accumulate, even if the patient does not assume the dorsal position at all.

ON PUERPERAL FEVER.

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(*Read before the Medico-Chirurgical Society of Montreal, Feb.*, 1884.)

Nomenclature.—At the last meeting of the British Medical Association, Dr. Thorburn endeavored to impress the profession with the necessity of changing the old and time-honored name "Puerperal Fever" to that of "Metria." He said that the old term did not cover the ground, for it was impossible to include epidemic puerperal fever under the same classification, or the more sporadic forms. Matthews Duncan and others, it is well known, do not include zymotic diseases with septicæmia as etiological factors; they wish to make puerperal fever a disease *sui generis*. Yet it is also well known that the poisons of scarlatina, erysipelas and typhoid fever may sometimes cause in the puerpera symptoms scarcely distinguishable from those of puerperal fever. In this case the woman has simply scarlatina, not metria; but a woman who has rigors, high temperature, intense tympanites, and rapidly dies, with subsequent clear proof of scarlatinal infection, has died of puerperal fever or metria caused by scarlatina.

I do not intend to defend Dr. Thorburn in his views, but merely place them before you. Neither do I feel that they are devoid of sound reasoning, and I think, as he does, that there would be no difficulty in conceiving how a tolerably definite train of symptoms ensuing from the action of septic or zymotic germs in the hyperfibrinated blood of a puerpera may take on a uniform character and epidemic virulence.

In a recent paper read before the New York Academy of Medicine by Dr. T. G. Thomas, the author pronounces emphatically against the change of name. He says, of the two names, "puerperal fever" is the least objectionable, but shows a decided leaning towards the term "puerperal septicæmia," as indicating the more correct teaching from a pathological point of view, using the words of Barnes, "the blood of the puerpera is empoisoned."

Etiology.—At all the recent discussions on puerperal septic

fever, its etiology seemed to give rise to little diversity of opinion. All agree, I think, at present that it is due to those conditions pointed out by Dr. Lombe Atthill. First, that puerperal women are inoculated with septic matter conveyed to, and deposited in, the vagina by the hands of the attendants and other agencies; and, second, the patients may become victims of auto-inoculation, the poison originating within their own bodies from decomposition of blood-clots and placental remains after parturition. Dr. Atthill further contends that there may be a cause over which antiseptic precautions have no control. He says that there are instances of continued uterine relaxation where the uterus does not seem to permanently contract, but allows the formation of large clots to take place within the cavity, and that on their decomposition the disease is thus produced. Here it is clearly indicated we should employ ergot with an unrestrained hand, and continue its administration for several days after labor. Much difference of opinion has been expressed in regard to the prudence of practitioners or students attending puerperal women immediately after handling dissecting material or post-mortem cases. Löhlein and Fritsch are of opinion that if proper disinfection of the hands is practised, it is all that is necessary, and that fresh cases can be attended with impunity; but recent experiments have undoubtedly shown that micro-organisms are not so easily destroyed by antiseptics, and I doubt very much if merely washing the hands in antiseptic solutions will obviate the risks of inoculation after handling septic material.

Coexistent with these causes is a condition most favorable to the reception of poison-secretions into the blood of a puerperal woman—always a most prolific soil for sepsis and zymosis. I allude to lacerations of the genital tract. And I firmly believe that the strenuous opposition shown by a section of the profession to the immediate operation for lacerated perineum has a great deal to answer for in deaths from septicæmia. I have published cases myself of this disease which were undoubtedly traced to this cause, and which should never have occurred had these lacerations been attended to at the time of delivery, and proper antiseptic measures taken in their after-treatment. It is gene-

rally thought that fresh, healthy, non-offensive lochial discharge is harmless, and not capable of setting up a morbid state in the puerpera; but we find that as far back as 1843, Scherer found that secretions taken on the third day after delivery from a puerperal woman and injected into a healthy pup produced its death in two days. Examination showed extensive inflammation of the muscles and connective tissue, collection of hemorrhagic exudations, and intense inflammation of the kidneys. Rokitansky and Kehrer also arrived at the same result in like experiments. In a few days after delivery, the pure blood tended to diminish and the pus to accumulate, bacteria were found, chiefly of the spheroidal form.

When we are aware of such facts as these, and with solutions of continuity of the genital tract, we have, 48 hours after delivery, a rise of temperature, a slight chill, some abdominal pain with headache, the lochia have been normal, though irritating enough to produce a slight lymphangitis, but not sufficiently poisonous to produce erysipelas. Yet, as Thomas has pointed out to us, recovery from parturition is the rule, notwithstanding all these circumstances which are best calculated to ensure a bad ending. Now and then, however, the matter does not end with these symptoms of slight illness. The poison gains admission higher in the genital tract, increases in its violence, acts rapidly, as does yeast on dough, alarming phenomena follow, until eventually death takes place.

Pathology.—As regards the pathology of puerperal fever, I think it is fairly well accepted to be "a septicæmia" attacking the puerperal patient, and that the essence of the disease is absorption of poison into the blood through some breach in the genital tract. Lusk's* definition is a good one: "The septic inoculation of wounds which result from the separation of the decidua and the passage of the child through the genital canal."

It is, however, to be regretted that this clear and comprehensive view of the pathology of this disease is not wholly free from dissent. It is held that a certain form of the disease termed "sapræmia" is dependent upon the absorption of putrid

* Semmelweis and Hervieux.

matter independent of the influence of micro-organisms. The existence of such a condition I hold to be utterly impossible, and to be at variance with results derived from recent experimental research. Ogston's experiments on this point are of singular interest. He found that micro-organisms were present in all acute, but *not* in chronic, abscesses. Twenty experiments were made on guinea-pigs and mice by injecting pus from cold abscesses into the tissues of the back. "The invariable result was that no illnesses or abscesses ensued; that the pus was, within a week, dried up into a film pervaded by living cells; and that within ten days this film had become totally absorbed, so that no trace of it remained when the animals were killed, and the site of it was not discovered." But when pus from an acute abscess containing micrococci was injected in the same manner, symptoms of blood-poisoning ensued and lasted from two to five days, and after a few more days the animals recovered. And from other experiments it would appear that to have puerperal septicæmia, we not only require the presence of germs in contact with wounds of the genital tract, but also that there be a quiescent state of dilute albuminous fluids supplied for them to live upon, and increase in their virulence, by means of a process of fermentation. The principle of thorough drainage is based upon these truths; it prevents the occurrence of the very conditions above-named, so essential to the thrift of the septic organisms. It must also be remembered that whatever tends to disturb the equilibrium between absorption and excretion, so active in the puerpera, favors germ activity, and it was here that aconite, which obtained so much renown some years ago as a remedy in puerperal fever, exerted its good influence.

Treatment.—Of the different interesting points of this disease, there are none so interesting and important as the one which appertains to the prevention of the disease occurring, and its cure when it does occur. Herein lies the great battle-field of opinion. Extreme views, often diametrically opposed to each other, are held by our most experienced observers. The list of precautionary measures which Dr. Thomas gives us is almost impossible for ordinary men to carry out in detail. He views every parturient woman in the

light of one who has passed through a capital operation. Dr. Wylie treats the genital canal after labor as a punctured wound. And the question before us now is, how far the learned discussions of these gentlemen are going to help us, and how religiously are we to obey the demands of their creed. Dr. Thomas tells us the wall, floor and furniture of the room of every patient are to be washed with a 10 per cent. solution of acid. carbol., or 1–1000 of Hydrg. Bichl. All curtains removed. Six or eight hours after labor he washes out the vagina with antiseptic solution, and introduces a suppository of iodoform. The injections are repeated every eight hours. If instruments have been used, inject every four hours, and keep up for ten days. Dr. Thomas lays special stress on the physician's attending to details himself, and giving ergot three times a day for a week at least to ensure proper contraction of uterus and expulsion of clots, etc.

During the discussion on Dr. Garrigues' paper there arose a storm of opinion. Dr. Garrigues does not use prophylactic vaginal antiseptic injections in normal labors. He simply washes the external parts after labor with $\frac{1}{1000}$ parts of Hyd. Bichl., and then uses antiseptic absorbent napkins, changed every four hours. It is, in fact, the nearest approach to antiseptic dressing as carried out by the surgeon in cases of amputation. In the discussion, Dr. Baruch claimed that in 15 cases in which three per cent. solution of carbolic acid was used as a vaginal injection twice daily, he had observed six cases of undoubted septic poisoning. This result, he claimed, was due to disturbance of patient, entrance of air, and infection by syringe, &c. Dr. Garrick cited 4,000 labor cases, with a mortality of two from puerperal fever, under strict cleanliness alone. Intra-uterine injections for prophylaxis were, of course, not entertained.

Judging from the foregoing, I am inclined to think that the difficulty in arriving at a definite and unanimous conclusion in regard to the advisability or otherwise of using prophylactic vaginal injections is based upon the fact that inert antiseptics are generally used in such cases. I am convinced, from the results of a fair trial of many of the ordinary so-called antiseptics in general use, that they are uncertain; troublesome from the

necessary frequent repetition of them; dangerous from the careless way in which they are used by ignorant nurses, and through second hand and infected syringes; and that they should never be resorted to unless under the following conditions:—

1. No solution should be used as an injection but that of Hydrg. Bichl. $\frac{1}{5000}$ strength.

2. A perfectly new fountain (No. 2) syringe should *only* be used in each case; better none than a second-hand one, no matter how apparently perfect.

3. No injection should be given until the day after the confinement, and one injection daily is sufficient; sometimes one every second day will be consistent with safety of patient.

4. The physician should perform the operation himself; on no consideration trust a nurse; better leave it undone.

5. See that the syringe is playing before introduction of nozzle, to prevent entrance of air.

6. A convenient solution of corrosive sublimate can be made by dissolving one drachm (℥i) of the salt in one ounce (℥i) of alcohol. One teaspoonful (℥i) of this solution added to one quart of warm water will give almost to a fraction one part in two thousand $\frac{1}{2000}$ and will be sufficient for each injection. This injection can be continued for almost any length of time, the absorbent power of the vaginal mucous membrane being very low.

7. Provided there is no cause for *intra-uterine* decomposition—which every careful physician should satisfy himself of before leaving his patient at time of confinement—my experience has led me to think, that it is not possible to have a patient attacked with puerperal septic fever in private practice while observing the above indications.

In the treatment for cure, when the disease has set in, Dr. Thomas uses the intermittent intra-uterine injections of carbolic acid solution (2 per cent.), or solution of corrosive sublimate 1 in 2000 parts. (Cannot continue injections of solution of Bichloride (intra-uterine) for more than three or four days, one injection each day, without producing constitutional effects from absorption of drug. I have produced slight salivation upon two

occasions on the fifth day.) Dr. Thomas looks upon constant irrigation as a mistake. To control temperature he uses Townsend's rubber-tube coil, extending from the ensiform cartilage to the symphysis pubis, with ice-water flowing through it. He also gives quinine in full doses night and morning.

In considering the curative treatment, it will be remembered that last year I brought before this Society the record of three cases of puerperal sepsis, in which I had used suppositories of iodoform, each containing gr. x Iodoform in Ol. Theobroma, *made by pressure*, with very marked success.* I have now to present to you three more cases treated in a similar manner, with the exception that to the suppositories of iodoform *was added an equal quantity of boracic acid*, and which I have every reason to believe increased the efficiency of this particular form of treatment. Boracic acid, I think, may be placed close to the salts of mercury and silver as a non-irritant germicide. I have kept meat-extract perfectly pure for months in a solution as weak as three grains to the ounce of water.

The first of the three cases I shall speak of was a woman of about 30 years of age; had had five children. She was confined on the 19th of last March without instrumental aid. She objected to have vaginal injections, saying that she never used them, and did not think she now should deviate from her old customs. All went well until the morning of the 22nd (the third day after confinement). She was then seized with violent pelvic pain and a succession of rigors, intense headache, temperature 104°F., pulse 120. On examination, I found that a prune-juice-looking discharge was oozing from the cervix, but was non-offensive. I administered a hypodermic of Battley's solution, and washed out tne uterus with about two quarts of 5 per cent. solution of carbolic acid and passed up two suppositories; also ordered gr. xx of quinine to be given that afternoon. She did not change much during the day towards improvement, so I injected the uterus again that night and passed two more suppositories.

* "On the treatment of Puerperal Septicæmia by a new method—intra-uterine suppositories of iodoform." *Can. Med. & Surg. Journal*, April, 1883.

The following morning her temperature had fallen to 101°F. and pulse to 100. She had no more pain since yesterday, and was feeling well, with exception of some pelvic tenderness on pressure. Washed out uterus again with solution of carbolic acid, and two more suppositories were passed. Temperature and pulse that evening same as in the morning. Did not wash uterus out, but passed two more suppositories. For the following two days she had no other treatment than the introduction of two suppositories night and morning. Her temperature and pulse were normal, and I concluded all was over. For the following two days nothing whatever was done, beyond keeping her quiet in bed, and, to my great dismay, on the morning of the next day she was seized with a violent chill; temperature 105°F. and pulse 140; no pain. This was on the fifth day from first inception of sepsis, and was a relapse due to accumulation of fresh poison. She was now terribly reduced in strength, and like anything but a woman who could survive so severe a storm. However, I again thoroughly washed out the uterus with a very strong solution of carbolic acid, and passed up two suppositories. The same was again done that night. The following morning her temperature and pulse were much reduced, and she continued to improve from this time, the suppositories being used night and morning for some time, and the injections only occasionally. I did not, however, discontinue the treatment until I was quite satisfied a relapse would not be likely to occur again. I may state that this patient was a miserably-nourished woman at beginning of labor, and on its completion the uterus became extremely anteflexed, producing a kink at the cervix difficult to overcome, which may have had something to do with retention of clots.

The next case was that of a strong, healthy French-woman. She was confined, also without instrumental aid, on the 20th of March, the very day following my attendance upon the previous case. Vaginal injections of carbolic acid were here used from the outset. On the third day she was seized with a severe chill and pelvic pain, high temperature and rapid pulse. The same treatment was followed as in former case, with the exception of

the uterus being washed out *only once*. The suppositories were used night and morning with good effect, but though she improved during the following week, still she did not have a decided fall of temperature and pulse as I was accustomed to see in former cases. On the sixth day, a large fetid clot of blood was expelled, which was causing all the trouble, and which was probably infecting the placental site with fresh poison as fast as the suppositories were destroying it. From this out she rapidly improved, the treatment being continued for some days afterwards. It may here be of some interest to state that I had been, the day previous to attendance upon the first of these cases, for over an hour in the room of a patient dead of malignant disease of the kidney and peritonitis, on whom a post-mortem was being performed. This circumstance may have formed a link in the chain of causation, or it may not. It is, however, a very nice point for discussion, and will, in future, be a good lesson to me to avoid a like risk.

The third case was a young, powerfully-built primipara. I attended her on the 28th August last, and delivered her with forceps of a very large child. She was treated during the puerperium with vaginal carbolized injections, and made a very good recovery. She left her bed as convalescent on the ninth day. She began house-work immediately, and on the 11th September, fourteen days after labor, was seized with violent pelvic pain, severe rigors, intense headache, high temperature, and rapid pulse. On examination, I found a stellate laceration of the cervix, with blood oozing from each little radiating fissure. I washed out the uterus with a solution of corrosive sublimate $\frac{1}{2000}$ *once*, and used the suppositories as before. This was done again the next day, when all symptoms of a serious nature began to subside. The treatment was continued, however, for six days, after which she became again convalescent. This was really the most troublesome case I had ever had, from the fact that she was very ignorant, and possessed the most vile temper I ever experienced in a woman under such circumstances. However, I turned all her relations out of the room, and fairly subdued her into allowing me to perform the necessary operations. To act otherwise, I felt she would almost surely have died.

The method of introducing the suppositories is very simple. The perineum is retracted with a Sims' speculum in Sims' position, and the suppository passed up to the fundus uteri on a stilette sponge-tent inserter. I have been in the habit of introducing two suppositories night and morning, equal to 40 grains each of iodoform and boracic acid, daily. I see, however, that Ehrendorfer of Vienna has lately been using much larger doses of iodoform in similar cases, after my method, without evidence of absorption of the drug. I believe it to be quite immaterial what excipient is used to form the suppository. I like cocoa-butter and pressure, and find, by the experiment of dropping one of such suppositories in a glass of water at blood-temperature, that its disentegration is almost instantaneous. In conclusion, I would recommend that no time be lost in putting into practice the method above described, after the first onset of untoward symptoms. And it should not be forgotten, amid the foggy confusion of conflicting views regarding what is septicæmia and what is not in any given case, that Burdon Sanderson has shewn us by direct experiment the certainty of increasing virulence of successive inoculations. The inference is here obvious.

QUARTERLY RETROSPECT OF SURGERY.

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Catheter Fever.—At a meeting of the London Medical Society, held in December last, Sir Andrew Clarke read a paper on "Catheter Fever," which excited considerable discussion amongst the surgeons present. By *catheter fever*, Sir Andrew means a low form of fever (often fatal) which follows the habitual use of the catheter in men about middle life, who are perfectly healthy, and with no discoverable evidence of disease, except a low density of the urine and a local condition of the bladder, which has given rise to the necessity for catheterization. When these cases prove fatal, Sir Andrew asserts that ofttimes no sufficient structural change is found in the kidneys to account for death. Sir Andrew Clarke, however, was only able to give the results of

one such necropsy observed by himself, but he quoted from Velpeau and Marx evidence in favor of his views. He held that the fact that this form of fever may arise in what seems to be good health is not well known among surgeons, and had no adequate place in English surgical literature or English surgical teaching of the present time.

"This fever," the reader of the paper says, "is neither distinctly uræmic nor distinctly pyæmic, and probably first begins in the nervous system; that the disturbance of the nervous system reacts, in the first place, upon the general metabolism of the body, and, in the second instance, upon the secretory organs, beginning with the kidney; that the effect upon the kidney may consist either in structural alterations in the kidney, invisible by the aid of our finest instruments of research, or (as seems more probable to Sir Andrew) in alterations of the constitution of the blood, that dynamic condition of its constituents in the renal vessels essential to the elaborative action of the excretory cells thereof; and, lastly, that the concurrence of these conditions may be, and often is, enforced by septic reabsorption into the blood." This definition is certainly vague enough, and may mean anything or nothing.

The prevailing healthy condition which the subjects of this fever suffer from is only apparent, as Sir Andrew Clarke admits there is low density of the urine, which means deficient excretion of solids, and the need of the habitual use of the catheter (or as Sir Andrew puts it, the entrance upon "catheter life") indicates the presence of some chronic urinary trouble. To put the matter plainly, the apparently healthy patient has been for some time suffering from enlargement of the prostate, with, probably, atony of the bladder. Sir Andrew asserts that where narcotics or anæsthetics are used in these cases, no catheter fever follows, and advises their use in persons entering upon habitual catheterism. Quinine, he says, has signally failed in controlling this fever, and he asks: What are the things to be employed on such occasions? and what is the sort of hygienic management to be followed, especially in respect to food and alcohol, which are so variously used on such occasions?

Sir Henry Thompson, in an able speech, described several forms of urinary fever which follow the use of the catheter, and are familiar to all surgeons. First, four or five hours after catheterism, and after the first passage of urine, the patient experiences a rigor, followed by fever, pains in back, and then sweating; these symptoms pass away slowly, no recurrence takes place, and the patient, in two or three days, is as well as ever. This Sir Henry calls an "acute transient attack," occurring in persons who have the most healthy renal organs, and occurs occasionally from a simple absorption into the blood-vessels of some small portion of the urine. The phenomenon above described, he thinks, may also arise from purely nervous causes. Another form of urinary fever is the acute recurring form. The patient has, as a rule, four or five attacks of fever, and always recovers with rest and care. There is also a third class of cases where death occurs from 24, 36, to 48 hours after the attack, evidently from shock of some kind. A shock, Sir Henry said, sometimes follows the simple passing of a bougie on a young man who has never before had an instrument passed, and we cannot but be struck with the close sympathy that is established between the urinary organs and the nervous system; and it is therefore not surprising that in a very few and exceptional cases, with no obvious disease existing in the organs, the passage of the catheter may sometimes bring about a fatal result in 24 hours, and no special lesions be found to account for it. These latter cases, Sir Henry says, have no right to be included under the name of catheter fever.

In cases of true catheter fever, when ending fatally two or three weeks after catheterizing has been commenced, Sir Henry Thompson has invariably found, at the autopsy, advanced disease of the kidneys and ureters. Sir Henry pertinently remarked that it is not the attack of any catheter fever, but the want of a catheter at an early stage, which has placed those individuals suffering from enlarged prostate, with retention, in their dangerous condition. Where the residual urine is considerable, catheterizing mostly involves serious consequences, and Sir Henry insists on the necessity, in these cases, on the commence-

ment of catheterism, of keeping the patient in a warm room, without exercise, perfectly quiet, and on simple diet.

Quoting from the results of University College Hospital, Mr. Berkeley Hill said that out of thirteen necropsies made on men dying after the relief of retention due to enlarged prostate, in eleven there was interstitial nephritis, and in the other two the condition of the kidneys was not clearly stated.

Mr. Savory said the urinary organs were very delicate tests of reflex action, especially if any morbid condition were present. The passage of an instrument may be followed by a rigor, and this was of two kinds—physiological and pathological. The latter attended by rise of temperature ; the former not. He said that the cases to which Sir Andrew Clarke particularly alluded were cases in which constitutional disturbance or fever or pyrexia is produced by local irritation through the nervous system. He also dwelt strongly on the necessity, before operations, of examining the condition of the kidneys, especially as to the quantity of urea they are separating from the blood ; and with regard to serious operations, he would rather have thoroughly sound kidneys on his side than even a sound heart or lungs. He also remarked that in some of these cases which were said to have no appearance of mischief after death, the kidneys have still been at fault. In another class of cases where the kidneys are perfectly sound, Mr. Savory thinks we undoubtedly get blood-poisoning and septic inoculation after the use of instruments.

Mr. Harrison (Liverpool), in withdrawing residual urine in cases of enlarged prostate, substitutes an antiseptic fluid for the urine withdrawn. He said that English surgery was not only cognizant of, but prepared to meet, such cases as those to which Sir Andrew Clarke referred.

Since the discussion, the various English journals have been full of the subject of catheter fever, and one good has been to direct surgeons more particularly to this form of urinary fever, and to more widely make known its proper treatment. The opinion of most surgeons is that Sir Andrew Clarke has not told them anything new, that the disease about which he raised such a discussion was one that every experienced surgeon was

perfectly familiar with, and that his assumption of the *role* of surgical preceptor has been quite unnecessary.

Mr. Henry Morris (*Lancet*, Dec. 22nd, 1883), referring to the fever which follows catheterism in persons suffering from enlarged prostate, says it is to the state of the kidney prior to surgical treatment, and not to the state of the bladder after the commencement of catheterism, that we ought to look for an explanation. The granular kidney, or the kidney which has been changed by chronic insterstitial nephritis, becomes the seat of acute suppurative inflammation, perhaps throughout, but more likely in areas. Two conditions are requisite—(*a*) a pre-existing degeneration of the secreting structure; (*b*) an alteration from obstruction, in the intra-renal pressure, whereby the ureters, pelvis and calyces of the kidney become dilated. When these two conditions exist, a state of active congestion of the kidney is brought about by the release of the distension by means of the catheter, the elasticity of the kidney having been destroyed by previous disease, this increased flow of blood cannot be controlled or checked, and acute pyelo-nephritis sets in upon the top of chronic interstitial fibrosis. Mr. Morris, in such cases, advocates the recumbent position for some days after the commencement of catheterism, as that posture may favor the gradual change in the renal pressure. The diet should also be restricted, and ergot of rye given in moderately large doses.

Treatment of large Bronchoceles.—The removal of large bronchocele by the knife has, since the introduction of antiseptic surgery, become much more common. Billroth holds that simple primary thyroid cysts may be radically cured by puncture and injection of iodine. Larger bronchoceles, which cause dyspnœa, had better be removed by the knife. These, when even very large, if situated in the middle line of the neck, can usually be easily and successfully removed; but deep-seated substernal or unilateral bronchoceles are much less favorable cases for operation. Every bronchocele is encapsuled, and if care be taken, and the large vessels entering the tumor tied before division, removal can be complete. Mr. Thornley Stoker has lately reported a case of removal of an enormous bronchocele to the

Irish Academy of Medicine (*Dublin Med. Journal*, Sept., '83). The tumor occurred in a boy, and extended from ear to ear, and hung down as low as the navel. Two-thirds of the mass comprising the right lobe and isthmus was removed in March, 1882, and the remainder on the left side a year later. Complete recovery followed the first operation, but the patient died five days subsequent to the second from pulmonary thrombosis.

Mr. Henry Smith (*Lancet*, Jan. 5, 1884) reports two cases of bronchocele successfully treated by the seton. The first case was that of a man who had a great enlargement of the right lobe of the thyroid, which caused cough, dyspnœa, and general weakness, so that he could not attend to his duties. He was advised to have the tumor removed, but refused, so Mr. Smith, after puncturing the tumor with a small trocar, passed a needle around by a double hempen thread through the opening, carried it deeply into the substance of the swelling, and brought it out on the other side. The threads were tied together and left to act as a seton. Great local irritation was produced, accompanied with a free purulent discharge. As there was considerable fever, the seton was withdrawn and a drainage-tube introduced. The tumor gradually decreased, and the man left hospital still wearing the tube. After a time it was taken out, and when the man was exhibited to the students, there was no appearance of the tumor, beyond a very slight thickening, and the man was in perfect health. The second case was that of a woman, aged 68, who had suffered from bronchocele for 16 years. The tumor involved the whole gland, and produced much distress, with dyspnœa. A seton was introduced and left in for 16 weeks; free discharge ensued, and the tumor rapidly decreased in size. The difficulty of breathing disappeared, and when shown to the students, there was hardly any trace of the tumor.

Although bronchoceles have been frequently removed, still, notwithstanding the greatest precautions, the operation is always a formidable and frequently a fatal one, so that the method advocated by Mr. Smith deserves trial.

There is still another method, which has only lately been introduced, for the removal of the grave dyspnœic symptoms often

produced by these large tumors, and it has lately been tried with success by Mr. Sidney Jones, of St. Thomas' Hospital, London. (*Lancet*, Nov. 28, 1883.) This method also involves an operation, but one which is much less serious than that required for the removal of the entire gland. The method is one which has been practised on the Continent for some time, and is the removal of the isthmus of the gland only. In Mr. Jones' case there was severe dyspnœa, and the structures in front of the isthmus were carefully divided, the veins being tied before division, and the isthmus was detached by the finger and director from the front of the trachea. An aneurism needle, armed with a double ligature, was made to perforate the junction of the isthmus with each lateral lobe, and the double ligature on each side was tied as with an ovarian pedicle. The isthmus was then cut away and the ligatures left hanging out of the wound for drainage; a drainage tube was also inserted, and the wound dressed antiseptically. A month after the operation, the thyroid was scarcely perceptible, and the difficulty of breathing had entirely disappeared. In other cases of removal of the isthmus, a similar atrophy of the lateral lobes has been noticed. The late Dr. G. D. Gibb many years ago advocated the division of the thyroid isthmus to relieve the severe dyspnœa which occurs in large bronchoceles.

Prof. J. L. and Dr. A. Reverdin (*Revue Med. de la Suisse Romande*, 1883) give an account of 22 extirpations of the thyroid gland performed by them on 21 patients, 12 of whom were women. The size of the tumors varied from a hen's egg to that of an adult's head. In 17 cases total extirpation was performed. Two cases died. The average time in hospital was sixteen days. The Messrs. Reverdin were able to examine their patients several years after the operation, and then discovered certain remarkable alterations of the general health that showed themselves several months after operation in five patients, three of whom were women. There was first weakness and coldness of the limbs, then loss of appetite, slowness of speech, diminution of memory, and progressive anæmia, accompanied, in two cases, by a peculiar œdema, most marked on the face, and very anala-

gous to that which occurs in myxœdema. These symptoms partially disappeared after three years. Messrs. Reverdin say they appear after total extirpation, and are produced by a lesion of the vaso-motor nerves, and by a mucoid infiltration of certain tissues in consequence of the removal of the gland. The Messrs. Reverdin recommended extirpation of the thyroid when there are symptoms of imminent danger, such as attacks of suffocation, and also in cases of retro-sternal or rapidly-growing goitre, when ordinary treatment has proved useless.—(*Condensed from Brit. Med. Journal*, Sept. 29, 1883.)

Amputation in Senile Gangrene. —At a meeting of the Royal Medical and Chirurgical Society of London, held Dec. 11th, '83 (*Lancet*, Dec. 15th, 1883), Mr. Jonathan Hutchinson read a paper advocating the treatment of cases of senile gangrene by high amputation. He urged the safety and expediency of amputating in senile gangrene if the operation were done at a good distance from the disease. In the common form of gangrene of the toes and foot, the lower third of the thigh was the part suggested as the proper level of the amputation, and in the rare cases, in which the hand was affected, the middle of the upper arm. The author stated that the reason amputation had fallen into disrepute was because the disease returned in the stump owing to the amputation having been performed too low down. The calcification of the arteries on which, in the main, the disease depended, was usually greatest near the periphery, and hence the difficulty as to supply of blood to the flaps. This source of danger is not met with if the operation be performed sufficiently high. In a series of cases in very old persons, the reader of the paper had only seen recurrence of the gangrene in one. In three the stump had healed well; in a fourth, in which the patient, although not old, was prematurely senile and the calcification of the arteries extreme, the recovery had also been excellent. One of the patients in whom the stump had healed without a drawback was 70 years old. As to the time to be selected, the author thought that as soon as the patient was so ill as to be confined to bed, and the disease well established, it was best to operate. Spontaneous cure was, he urged very

exceptional, and a great majority of such cases ended in death, with much suffering. The thinner the patient the less was the risk of the amputation. In a few cases where the thigh was exceptionally fat and the tissues flabby, it might be wise to hesitate as to recommending it. In all Mr. Hutchinson's cases Lister's precautions had been carefully used, and in two or three the patient had never experienced the slightest pain from the day of the operation.

In the discussion which followed the reading of the paper, Mr. Rivington supported the views of Mr. Hutchinson, and said he had amputated successfully in two or three cases. Mr. Hulke had seen cases of spontaneous recovery after senile gangrene of the foot and lower third of leg, and his experience was in favor of conservative treatment. Mr. Cripps advocated amputation lower down than Mr. Hutchinson. Mr. Savory said the causes of senile gangrene were partly local and partly constitutional; when these reached a certain stage gangrene ensued, but in some the local causes were predominant, and in others the constitutional were most efficient, and as regarded treatment, the two classes could not stand in the same category. If the mischief depended chiefly upon the constitutional cause, amputation would not be successful; if upon local causes, it would. In typical senile gangrene, where the vessels are calcareous, a very trivial cause might start it; but in others, a considerable injury might originate it, and the same thing might occur in younger people, where the tissues were rotten. Where there had been a considerable amount of injury, he thought amputation would be useful; but in the typical form of senile gangrene, amputation, high or low, would be attended with disaster.

Mr. Hutchinson, in reply, said that he thought the abolition of shock by anæsthetics, the bloodless method of operating, and rapid primary healing of the amputation wounds, placed the question of such an operation in quite a different light from that in which it had previously been; however, if the spontaneous separation of the sphacelus were probable, and would leave a more useful limb than that made by a surgeon's amputation, he would, of course, prefer to leave the patient to the slower process of natural amputation.

Mr. James, of the Exeter Hospital, has reported a series of five successful cases of high amputation for senile gangrene in very old persons. I have at present under my care a case of senile gangrene of the moist type, where a line of demarkation formed about the middle of the right foot. The gangrenous part was separated at the tarso-metatarsal joint quite lately, and the case has progressed most favorably, a useful foot being left. At one time high amputation was thought of, but a line of demarkation forming, the idea of amputation was abandoned. The patient's arteries were very calcareous. Opium and stimulants was the principal treatment.

Radical Cure of Exomphalos.—Mr. Lawson Tait (*Brit. Med. Jour.*, Dec. 8, 1884) says that a hernial protrusion at or near the umbilicus is an exceedingly troublesome condition in the adult. In children, in the majority of cases, it can be cured by the careful use of a well-fitting truss. It occurs chiefly in fat women, or in those whose abdominal walls have been greatly stretched by many labors or by large tumors. In cases occurring in adults, trusses are of little service, Mr. Tait says, so he advises operative interference. He has had eleven cases, all successful. He opens the sac, frees all adhesions, removes redundant and irreducible omentum, pares the edges of the ring and stitches them together with continuous silk thread, which he leaves permanently there. He has traced three of the patients thus operated on, and finds that the cure of the protrusion is permanent after eleven, eight and five years respectively. All the patients operated on have been very fat, and the last one was pregnant. Mr. Lawson Tait, in conclusion, remarks that if he is ever called upon to operate in a case of strangulated hernia, he will proceed by abdominal section, and complete the radical cure of the protrusion at the same time that he relieves the obstruction.

New method of treating Psoas Abscess.—Mr. Fred. Treves read a paper at the meeting of the Royal Medical and Chirurgical Society of London, held January 8th, 1884, on the *Direct Treatment of Spinal Caries by Operation.* He said (*Lancet*, Jan. 12, 1884) the gravity of spinal caries depends, not so much

on any special pathological features in the process, as upon the depth at which this disease is situated and its inaccessibility to the usual operative procedures applied to caries elsewhere. Diseased bone cannot be removed from the vertebral bodies, and the morbid products having to travel a great distance in order to be evacuated, are apt to induce immense purulent collections. These collections are usually opened at a point remote from the original seat of the disease. In the operation proposed by Mr. Treves, the anterior surfaces of the bodies of all the lumbar vertebræ and the last dorsal vertebræ can be reached from the loin; a vertical incision is made near the outer edge of the erectors spinæ, the sheath of that muscle and the quadratus lumborum are cut through, the psoas muscle is incised, and the vertebræ reached by continuing the operation along the deep aspect of that structure. By means of this operation the vertebræ can be readily examined, carious or necrosed bone can be removed, a ready and direct exit can be given to all morbid products, and an abscess situated in the psoas muscle or in the lumbar region can be evacuated while it is yet small, and before it has led to a large abscess cavity. If a large psoas or lumbar abscess exist, it can be evacuated at its point of origin, and at a spot that, in its recumbent posture, corresponds to its most dependent part. If Hueter's statement be true, that the two vertebræ most frequently attacked by caries are the last dorsal and first lumbar, the operation should be of frequent application. The author details three cases of this operation; all made a good recovery. In one of the instances, he evacuated at its point of origin a psoas abscess containing 40 ounces of pus, and removed from the body of the first lumbar vertebra a large sequestrum. The immediate improvement in this patient's condition was very marked. In another case, a psoas abscess had been opened in the thigh some months previously. By this operation, a counter opening was made at the point of origin of the abscess from the lumbar spine, and the entire abscess cavity was drained by a tube passing from the origin of the psoas muscle to its insertion. Mr. Treves added that, with regard to the last case in the paper, the patient did well, but the boy had chronic lung disease, the

drainage-tube had to be removed, and he died with extensive cavities in the lungs and amyloid disease of the liver and kidneys.

In the discussion which followed, most of the speakers agreed as to the value of opening a psoas abscess at its point of origin and so securing free drainage, but condemned the cutting down on the diseased spine for the purpose of removing carious bone.

Mr. Furneaux Jordan has recommended a somewhat similar operation for the treatment of psoas abscess if the ordinary method is unsuccessful. Dr. McEwen of Glasgow treats psoas abscess by cutting down on the diseased spine.

Dr. Norman Chavasse of Birmingham published a lecture in the London *Lancet* for December 29th, 1883, in which he advocates opening psoas abscess by a posterior incision. His mode of procedure is as follows: An incision is made immediately above the crest of the ilium, commencing at the edge of the erector spinæ muscle and carried three or four inches transversely outwards towards the anterior superior spine; the various structures are divided, as in colotomy, till the quadratus lumborum muscle is reached. The forefinger should then be passed downwards and forwards on the iliacus muscle till the tense and distended psoas sheath is detected. A scalpel should then be introduced along the finger and the abscess incised, the opening being enlarged by dressing forceps. A drainage-tube should be introduced, and the wound treated antiseptically. Mr. Chavasse reports two successful cases treated on this plan. He says that to Prof. Chiene of Edinburgh is due this method of treating psoas abscesses.

Treatment of Nævus.—Mr. W. Beatty, in the *Brit. Med. Jour.*, Nov., 1883, notes that he has had great success in the treatment of nævi by the local application of arsenic. The preparation used is the ordinary Liquor Arsenicalis of the Pharmacopœia, with which the nævus is to be painted night and morning until ulceration takes place. The cure is effected in from three to five weeks.

Treatment of Phagedænic Chancre.—For ordinal cases, Vidal (*Bull. de Méd. Gén.*, Nov., 1883) uses an ointment composed of pyrogallic acid 40 grammes, vaseline 120 gr., starch 40 gr.

When the ulcer has a very irregular surface and undermined edges, the best plan is to use a powder of pyrogallic acid 20 parts to starch 80 parts, which can be blown upon the part twice daily by means of a small pair of bellows.—(*London Medical Record*, Feb., 1884.)

Prevention of Bedsores.—Dr. H. Snow (*Brit. Med. Jour.*, Dec., 1883) recommends the use of the compound oil of hypericum in the treatment of bedsores. It induces healthy granulations, and does not produce any smarting. A bottle should be half filled with the flowers of St. John's wort, olive oil should then be added, and the bottle allowed to stand in the sunshine for some days till the oil becomes of a deep red color, then it is brushed over the sore two or three times daily.

Treatment of Chronic Urethritis.—Guyon says the internal treatment is very important, and differs (*Bull. de Méd. Gén.*, Nov., 1883) according to the constitution of the patient. Cod-liver oil, with creasote, arsenic, iodide of iron, sulphur, and the balsams are the best remedies. The local treatment consists in injections, instillations, cauterizations, or catheterism. Injections are too often valueless, as they do not always reach the bulbous part of the urethra. For instillation, Guyon uses a tube provided with a small syringe, and by which a solution (generally nitrate of silver, 1 in 20 or 1 in 50) can be brought in contact with the deep part of the urethra. Catheterism is only justified in very intractable cases, and a large metallic sound is the best; medicated bougies are valueless. In cases of gonorrhœal cystitis, Guyon advises the injection into the bladder of 10 to 15 drops of a 1 to 2 per cent. solution of nitrate of silver. The injection must be repeated every day, and may be used in recent as well as old cases.—(*London Med. Record*, Feb., 1884.)

Conversion of Malignant Tumors into Innocent Growths.—In a clinical lecture delivered in Munich (*Wien. Med. Zeit.*, June, 1883), Dr. Nussbaum expressed a belief that he had discovered a procedure for the postive cure of cancer, by restraining the proliferation of the tissue elements of the disease. It appears to him that a total interruption of all peripheral sources of nutrition is the means best adapted to secure the result. He

accomplishes this object by the use of the thermo-cautery, with which instrument a deep channel is made quite around the malignant growth, thus cutting off entirely the supply of blood and other nutritive fluids from the surrounding tissues. The small vessels which ascend into the tumor from the parts beneath are sufficient to preserve its vitality, so that gangrene does not occur. He thinks the thermo-cautery far preferable to the ligature, and that it possesses many advantages over the knife. Prof. Nussbaum thinks that this method of circumscribing cancerous growths and cutting off every channel of peripheral nutrition has a brilliant future, especially in those desperate cases in which death is imminent from hemorrhage. In his hands this method has afforded satisfactory results.

Reviews and Notices of Books.

The Operative Treatment of Intra-Thoracic Effusion.—By NORMAN PORRITT, L.R.C.P., Lond., M.R.C.S., Eng., Hardwich Scholar in Clinical Medicine. London: J. & A. Churchill.

Since it has become the recognized treatment with all physicians to remove effusions into the pleural cavity when such have gained any considerable dimensions, it behoves every one to be acquainted with all matters concerning the *technique* of this now little thought of, but still important, operation. This is a very carefully prepared essay, entering thoughtfully into all the questions which may arise in the consideration of a case of thoracentesis. The author advises the seat of election for puncture to be "the 7th and 8th interspace, about the junction of the anterior two-thirds with the posterior third of the chest-wall," although the lateral region is preferred by many writers. On this point, our own practice corresponds exactly with that laid down, and we think there are good reasons for it. As to quantity of fluid to be removed, he would "limit it to two pints and to a less quantity than this should troublesome symptoms come on." There may be good grounds for this limitation, but we have many times aspirated a larger amount than this from

even a small chest, and have never seen anything to contraindicate it. For removing serous fluids Dr. Porritt objects to the aspirator except for localized or firmly encapsuled collections, preferring in all ordinary cases a trocar with syphon attachment. We are not satisfied that his arraignment of the aspirator is sufficiently supported, and certain it is that many of the best operators still use it exclusively and with entire satisfaction. As long as it is believed to be quite safe, its numerous and evident advantages will prevent its being replaced by any other mechanism. Southey's trocars are only alluded to in order to be condemned. We agree with this, for we have seen a case in the practice of a *confrère* where they seemed to have been the cause of a fatal termination. The subject of free incision in empyema is treated of exhaustively and scientifically. There are only a few points which we shall have space to notice. It is a delicate question whether an anæsthetic can safely be given. It is certainly always advisable, if safe. Dr. Porritt says: "Without any misgivings, I advise the employment of ether to the 'surgical degree.'" Quite recently it happened to ourselves to give ether for operation upon an empyema. Just as the cutaneous incision had been made, the patient's condition became so alarming that we were compelled to desist and postpone the operation. We would advise great care in the anæsthetizing of these persons. The operative treatment of limited empyema, of pneumo-thorax, of pyo-pneumo-thorax, and of hæmo-thorax, occupies the concluding chapters. We have had much pleasure in the perusal of this book, and recommend it to the attention of all who are interested in the diagnosis and treatment of chest disease.

On Bedside Urine Testing, including quantitative Albumen and Sugar.—By GEO. OLIVER, M.D., Lond., M.R.C.P., Lond. Second Edition. London: H. K. Lewis.

Dr. Oliver has been introducing to the profession the idea of replacing the old liquid tests for albumen and sugar in the urine by various test-papers. The advantages claimed for these—very great if proven—are their portability and ease of applica-

tion, reliability and the rapidity with which they act, and especially the fact that they can be made to reveal not only the presence of these abnormal ingredients, but also their *quantity*. The tests recommended for albumen are Potassio-Mercuric Iodide, Picric Acid and Sodium Tungstate. For sugar the paper used is saturated with Indigo-Carmine, the principle of which is a reaction discovered by a French chemist that "when the Carmine of Indigo is heated with Carbonate of Soda and a solution of glucose or Saccharine Urine, the blue color is converted gradually into green, then into red, and finally into yellow." If further experience confirms the observations of Dr. Oliver, it is quite probable that this method of urinary examination will, in great measure, supersede the older and more tedious and uncertain procedures.

Students' Manual of Diseases of the Nose and Throat.—By J. M. D. KITCHEN, M.D., Asst. Surg. to the Metropolitan Throat Hospital, &c. New York: G. P. Putnam Sons.

This is a small, handy manual, professing to be "a digest descriptive of the more commonly seen diseases of the upper air tract, with the methods of their treatment." It is evidently written by one who is quite familiar with the subject. It is concise, and the explanatory matters seem very accurate and clear. It will no doubt be found useful by students who, when they become practitioners, soon realize how common these diseases are, and how little they know about them.

Typhoid Fever in Victoria.—By JAMES W. BARRETT, M.B., Ch. B., Resident Medical Officer to the Melbourne Hospital. Section I. George Robertson, Melbourne.

This essay upon the most important zymotic disease of modern times is interesting, as showing the character and fatality of the complaint amongst our cousins of the Antipodes. It has been evidently prepared with great care, and is furnished with numerous statistical tables and linear diagrams in explanation of the text. The author is clearly an enthusiastic and

hopeful sanitarian. He dwells strongly upon the preventive nature of typhoid; shows how even restricted sanitary measures in his district have been followed by marked diminution in the number of cases. He would reject the idea of origin *de novo*, believing that decomposing sewage matters must first be contaminated with the typhoid stool before they can breed the disease, and adduces facts in support of this view. This corresponds completely with our own convictions in the matter. The adoption of this theory in no way detracts from the importance of thorough sanitary work for, in either case, cesspools and foul sewers are admitted to be the nidus or breeding-ground for the poison. We shall be glad to receive Dr. Barrett's further contributions to this most important subject.

Chemistry, Inorganic and Organic, with Experiments.—By CHARLES LOUDON BLOXAM, Professor of Chemistry in King's College, London, &c. From the fifth and revised English Edition, with two hundred and ninety-two illustrations. Philadelphia: Henry C. Lea Sons & Co. Montreal: Dawson Bros.

This is one of the best and most complete of the modern text-books of chemistry. It is well known by students and physicians, and needs no special notice. It is only necessary to draw attention to the fact of the appearance of this new edition. It is handsomely printed and profusely illustrated.

A System of Oral Surgery: Being a treatise on the diseases and surgery of the mouth, jaws, face, teeth, and associate parts.—By JAMES E. GARRETSON, M.D., D.DS., Dean of the Philadelphia Dental College; Surgeon in charge of the Hospital of Oral Surgery. Illustrated with numerous steel-plates and woodcuts. Fourth edition, thoroughly revised, with additions. Philadelphia: J. B. Lippincott & Co.

Of American books this is probably the best and most thorough upon a very important branch of surgery. After an extended description of the anatomy and functions of the

various parts to be found in the region of the mouth and jaws, the teeth claim the first attention, and an extended account is given of the defects and anomalies of teeth, their diseases, and the best means of treatment. This part, of course, necessarily deals with what falls almost exclusively within the domain of the dentist proper. But the latter half of the book makes it well deserving of being in the library of every practical surgeon, for it furnishes a very good account of the numerous affections of the maxillæ, the tongue, lips, tonsils, uvula and soft palate. It is profusely illustrated with woodcuts, and nine steel-plates, well executed, embellish it still further.

Cruise of the Revenue Steamer Corwin in Alaska and the North-West Arctic Ocean, in 1881.—Washington: Government Printing Office.

We have been favoured with a copy of this interesting compilation of the notes and observations of the scientific staff who accompanied this expedition. They are divided into medical and anthropological, botanical, and ornithological. The first of these is prepared by Dr. Irving C. Rosse, who has carefully studied the physical peculiarities, the linguistic affinities, the artistic instincts, and the craniology of the native Eskimos, and gives us a paper of much interest thereon. Lithographic plates represent the forms of skull prevailing amongst them. The botany of this far-away region is fully detailed with explanatory notes, and the birds and fishes are very fully described, and the rarer kinds are shewn in very beautiful colored drawings.

Books and Pamphlets Received.

STUDENTS' MANUAL OF DISEASES OF THE NOSE AND THROAT. By J. W. M. Kitchen, M.D. New York: G. P. Putnam & Sons.

ON BEDSIDE URINE TESTING, INCLUDING QUANTITATIVE ALBUMEN AND SUGAR. By Geo. Oliver, M.D., Lond. Second Edition. London: H. K. Lewis.

SAN REMO: CLIMATICALLY AND MEDICALLY CONSIDERED. By Arthur Hill Hassall, M.D., Lond. With numerous illustrations. London: Longmans, Green & Co.

A TREATISE ON PHARMACY, DESIGNED AS A TEXT-BOOK FOR THE STUDENT AND AS A GUIDE FOR THE PHYSICIAN AND PHARMACIST. By Edward Parrish. Enlarged and Revised by Thos. W. Wiegand. Philadelphia: Henry C. Lea's Son & Co.

PRACTICAL PATHOLOGY, A MANUAL FOR STUDENTS AND PRACTITIONERS. By G. Sims Woodhead, F.R.C.P.E. Philadelphia: Henry C. Lea's Son & Co.

A PRACTICAL TREATISE ON SURGICAL DIAGNOSIS, DESIGNED AS A MANUAL FOR PRACTITIONERS AND STUDENTS IN MEDICINE. By Ambrose L. Ranney, A.M., M.D. Third Edition. New York: Wm. Wood & Co.

THE INTERNATIONAL ENCYCLOPEDIA OF SURGERY. A systematic treatise on the theory and practice of surgery, by authors of various nations. Edited by John Ashurst, jr., M.D. In six volumes. Vol. IV. New York: Wm. Wood & Co.

VETERINARY MEDICINE AND SURGERY IN DISEASES AND INJURIES OF THE HORSE. Compiled from modern and standard authorities, and edited by F. O. Kirby. New York: Wm. Wood & Co.

A MANUAL OF PRACTICAL HYGIENE. By Edmund A. Parkes, M.D., F.R.S. Edited by F. S. B. François de Chaumont, M.D., F.R.S. Sixth edition, with an appendix giving the American practice in matters relating to hygiene prepared by Fred. N. Owen. Vol. II. New York: Wm. Wood & Co.

THE FIELD OF DISEASE: A BOOK OF PREVENTIVE MEDICINE. By Benjamin Ward Richardson, M.D., LL.D., F.R.S., &c. Philadelphia: Henry C. Lea's Sons & Co.

A MANUAL OF OBSTETRICS. By A. F. A. King, M.D. Second Edition. Philadelphia: Henry C. Lea's Son & Co.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, Jan. 25th, 1884.

T. A. RODGER, M.D., PRESIDENT, IN THE CHAIR.

Case of triple birth at 7th month of gestation, in two of the fœtuses development had been arrested at about 4th month.— Dr. Beaumont Small, of Ottawa, sent down the above 4 months' fœtuses along with the following history and remarks :—

The patient was a young woman of delicate health who had always been anæmic and troubled with menorrhagia. During the first four months of married life the prolonged menstrual periods continued without change. She then became pregnant, her general condition improved, but she persisted in performing heavy household duties. During the early months of pregnancy there is no history of any condition likely to cause injury to the contents of the uterus. During the last month before delivery there were marked signs of irritability of the uterus. Slight disturbances, such as driving over a rough road and jumping easily from a buggy were followed by pains and distress much

more severe than the causes would lead one to expect. About a week before delivery she fell upon her side receiving a severe shock, active pains ensued and continued until delivery. I was not able to find out if the membranes had been ruptured at the time of the injury. Upon my arrival labor was well advanced, the os fully dilated and waters discharged. During examination a loose body was detected projecting from the os which I endeavoured to recognise as an arm or leg. To my surprise it became loose and was easily withdrawn—proving to be fœtus No. 1, in a black, shrivelled, flattened state, differing very little from its present appearance. The flattening was due to compression between the head and pelvic walls. No placenta was attached. In a short time a well-nourished but lifeless fœtus of about seven months development was delivered: it had been dead for a day or two only. The placenta followed easily, there was no sign of its being a double organ, or of any attachment of the other fœtus. Shortly after fœtus No. 3 was removed with its placenta attached. This placenta was elongated and evidently fœtus No. 1 had been joined to it. Convalescence progressed favorably and the patient regained her comparative good health. There is no instance of multiple births having occurred in her mother's family. The cause of this unusual condition, I think, can be traced to the impoverished physical condition of the patient. The burden proved too great for the enfeebled uterus—the single placenta proved the stronger and attracted the greater show of nutriment—the other was correspondingly weakened and ultimately destroyed. Such instances of the power of toleration possessed by the uterus are rare. At a recent meeting of the Obstetrical Society of London a similar condition was reported in a twin birth. One other member only had met with the same in his practice.

Dr. Kennedy had never seen a similar case. He thought that pressure stopping the circulation was the cause of death of the specimens exhibited.

Dr. Wm. H. Hingston read the following paper on *Certain Forms of Club Foot*:—It is precisely one hundred years since, as Adams says, the treatment of club foot was limited to

mechanical appliances, when Thilenius proposed the division of the tendo-Achillis by an open wound; sixty-eight years since the division of the same tendon subcutaneously was performed—if Delpech's operation deserves to be so designated; and fifty-three years since Stromeyer improved upon the operation of Delpech by puncture and subcutaneous division. The modification of the operation of Thilenius, so far, concerned the manner of dealing with the tendo-Achillis, for to that tendon alone was imputed all the blame of the deformity, until comparatively recently, when other structures—tendinous, muscular, ligamentous, bony—have received attention. I intend here to speak only of that inveterate form of club foot; not of that simple form with which all are familiar, and which the nurse's, and, later, the mother's hand alone may remedy; nor of that other form which mechanical appliances may easily correct; nor of the milder form which tenotomy alone will cure; nor of a still severer form in which tenotomy of certain tendons, aided by mechanical appliances, suffices to remedy; but of that still severer form in which division of all the tendons and fascia commonly, or exceptionally at fault, followed by the use of the best mechanical contrivances, are powerless to remedy. One such case I exhibited to you last year, in the person of Emelie, aged 15 years, upon whom I had operated in the early part of 1881 for exaggerated talipes equino-varus. It may be in the recollection of some of you, that, when I showed to this Society the young girl in question upon whom I had performed the operation which had been introduced to the profession by Dr. Phelps, of Chateauguay, N.Y., based on the principle enunciated by Dr. Post, of New York, in dealing with wry neck, I mentioned that I had already, with the tenotome, divided, without much amelioration of the deformity, all the muscles usually at fault in this affection. There remained, to undo the excessive arch and shortening and doubling-in of the foot, excision of a portion of the tarsal bones; but the additional shortening of the foot that would result, not to speak of the considerable risk to limb and life of opening into the inter-tarsal articulations, made me disinclined to resort to it. You saw the result of the operation in

a completely straightened foot, without any diminution, but with increase of its length, and with but temporary impairment of its strength. The operation, so far as the members of this Society knew, was a novel one, and one not without the apparent qualifications of rashness.

I shall give short notes of a second, third and fourth, and two photographs of the last.

J. McG., æt. 19 years, the subject of exaggerated talipes equino-varus, entered the Hotel Dieu on 12th February, 1883. He had been born with the deformity, but, as years rolled on, the deformity had become greater. The heel was drawn up; the foot very strongly inverted, and bent inward upon itself. The patient walked on the outside of his foot; and the usual cutaneous and tarsal thickness existed there. I could not undo, in the slightest, this exaggerated deformity. I divided subcutaneously the plantar fascia, tibialis posticus, and anticus, and the flexor pollicis and long flexor digitorum, and, lastly, *as is usual with me*, the tendo-Achillis. With the exception of bringing down the heel somewhat, the deformity, notwithstanding considerable force, was not relieved—the excessive arch remaining as before. I then adopted free open incision; swept the knife across the sole of the foot, dividing tissue after tissue till the bones were reached. The excessive arch was then in great measure, but not completely, remedied. Across the ball of the foot a padded splint was applied, and on this, adhesive plaster to which were attached cords which led over pulleys, and a weight of 12 lbs. was suspended. With the exception of looking after the foot-piece, and sliding it nearer to, or farther from, the open wound, no surveillance was needed. The dressing consisted of vaseline for the first two days, and afterwards carbolic lotion or red wash, as suppuration was more or less abundant. When the patient left the hospital, on 30th April, his foot was quite straight and supported his weight comfortably. I have since learned that the foot is in every respect like the other.

Case III.—Is that of a boy, J. D., aged 10 years, who entered the Hotel Dieu under my care on 15th October, 1883, for double congenital talipes equino-varus. The deformity in

both feet, but chiefly in the left, was excessive, and no amount of force, even under chloroform, could diminish it. Subcutaneous division of the supposed faulty tendons of the left foot was performed, and in the order named in previous case; but, apart from giving greater freedom to the heel on the division of the tendo-Achillis, the rigidity and deformity remained. I then used the scalpel very freely to the sole of the foot, dividing all the tissues down to the bone, and gradually unfolded the excessive arch. This added most markedly to the length of the foot —the cut edges at their centre gaping apart to the extent of nearly two inches. I had difficulty in keeping up extension. The boy was a mischievous fellow, difficult to control. Pulleys were ineffectual, as they were tampered with either by himself or some other patient. But what was found to restrain him effectually was a quickly-setting plaster-Paris splint, with a fenestra opposite to the incision. Through this the gaping wound was filled with tow soaked in Peruvian Balsam and renewed once a day. Granulation went on with surprising rapidity to the end. (I may here say, by way of parenthesis, that Peruvian Balsam, used in this way, is, without exception, the best application with which I am acquainted, and fully merits the favor in which it is held by Sayre and others.)

Case IV.—This subject was the same as the preceding, the foot this time being the right one. As the deformity was not so great as in the left I hoped, by free subcutaneous division, to remedy it in great measure; but the relief obtained by tenotomy was so inconsiderable that I proceeded at once to treat it as I had treated the left. The order of division was as in preceding case, with this difference, that structures already divided subcutaneously required no further attention by the open wound. The great difficulty in the treatment of the second foot, as in the first, was to keep up proper extension. Every additional day in the hospital added to the boy's cunning and to his desire to display it, regardless of consequences, to the admiring patients around him. During my absence of a couple of days from the city the boy manipulated things as he wished; and on my return, finding the old state of things partially restored, I

put him again under chloroform and forcibly extended the foot. This forcible tearing open of a partially healed wound, I may add, was followed by more suffering than was the original operation.

CASE IV.

(*Before the operation.*)

In talipes equino-varus, however exaggerated the degree, there is, there can be, no contraction of either the abductor or

of the short flexor of the little toe. The plantar fascia is almost always at fault, and its division remedies to some extent the deformity. The division of the flexor brevis muscle still further relieves the tension; the separation of the flexor longus digitorum still further; division of the tendon of the flexor

(*After the operation.*)

longus pollicis still more markedly; and that of the flexor accessorius still further. The lumbricales, as they are on the

phalangeal side of the incision, escape division—while division of the tendon of the tibialis posticus completes in a satisfactory manner the relief of the deformity, unless, as in Case I., the long calcaneo-cuboid ligament, a much longer ligament than its name implies, be also partially severed. The hemorrhage is not what might *a priori* be expected. The internal plantar artery, 'tis true, is divided; but the external plantar, much larger than the internal, escapes division, if the knife be not needlessly carried beyond, or in front of, the base of the fifth metatarsal bone. Leaving the large external plantar untouched, its numerous distributing branches suffice to keep the muscles, and the digits and their appendages, abundantly supplied with blood. In no case was the temperature of the foot on the distal side of the incision lowered, and granulations sprang up as abundantly on that as on the central side. The internal plantar nerve is divided early in the operation; and, if the incision be carried too far back, the external plantar suffers also; but this would be unwarrantable. Respect for the arteries prevents our carrying the incision too far forward; and respect for the nerve too far backward.

A question will now obviously suggest itself: Why not divide all these muscular structures subcutaneously? And in the answer to which lies the gist of the whole question: the skin itself is largely at fault, and must be divided; and the division of the artery necessitates an open wound. In Case II. every muscle and tendon were divided down to the bone, but the relief was not what I expected till the unfolding process had gone on for several days after division. In the third and fourth cases (those of the young boy) I was disheartened at the imp's devices with the aid of other patients in the ward to relieve his foot of restraint. The weight and pulley were not equal to him.

The quickly-setting plaster, to which a little salt had been added, applied under strong extension, suited admirably in one foot; and in the other a simple and inexpensive device, suggested to me by Dr. Phelps, and which I now show to you, was used with satisfaction. Most of you are familiar with the method of

applying adhesive plaster around the foot, and along the outer side of the leg; but in this plan the plaster so applied is divided between its two attachments on foot and leg, and two pieces of thick wire, like telegraph wire, and made into hooks or two buckles, are attached, and these are drawn together with strings and tightened as the plaster loosens. This device is a simple, inexpensive and efficient one, and is much better than the single piece of adhesive plaster which, when it slips, becomes useless.

What is 1st, the position of the operation; and what are, 2nd, the limits of its application? It is a most useful one, and one which, compared with excision of a wedge-shaped portion of the scaphoid—an operation which hitherto has not met with any considerable favor—is simple, safe, and requires no dexterity whatever in its performance.

What are the limits of its application? These appear to me clearly defined: 1st. Eliminate all cases in which, by hand or by mechanical appliances, or by both, deformity can be relieved. 2nd. Eliminate all cases which can be relieved by tenotomy. 3rd. Eliminate all cases where these, or any of these methods, or all combined, may suffice; for in all those cases would the operation by open division be totally unwarrantable.

But in those cases of exaggerated club foot, as these now submitted, with excessive arching and shortening, and more especially with narrowing and rolling in of the foot upon itself, *which cannot be relieved by the usual methods*, operation by open division offers important advantages.

DR. SHEPHERD said that Dr. Hingston ought to be congratulated on the results obtained in the cases just quoted, and spoke of the success which Dr. Davies has in these cases, where he operates by removing a wedge-shaped piece from the scaphoid bone.

DR. HY. HOWARD asked Dr. Hingston if the wedge-shaped opening which fills with granulation tissue ever contracted later on, as he had seen operations on the eyelids, which, after healing, were perfect, become a source of trouble from contraction of the granulation tissue months after. In one of these cases,

that of a lad, it became necessary to perform a rhinoplastic operation. A bit of the cheek was transferred to the upper lid, and, later on, whisker hairs grew from this piece.

DR. HINGSTON said that in the face this was so—the tissue would contract; but in the foot, which, with each step, was stretched, this would not occur. In the girl operated on two years ago, there is no contraction.

DR. WOOD exhibited two *Albinos*, and gave the following particulars:—Two boys, aged respectively 9 and 6, with congenital nystagmus, the elder having also right convergent strabismus. They are both albinotic—white hair, eyebrows, skin, and choroid; also pink irides. The eyes are very sensitive to light, and the children are both myopic. They are now, and have always been, healthy. There is no other instance of albinism in family or in any of parental relatives. No parental consanguinity or chronic neurotic disease. Other children healthy; none dead. The children are perfectly intelligent, and the elder has learned to read, although he suffers from inability to bring about proper ocular fixation. The elder child has fair distant vision, though they both suffer from amblyopia. Excitement of any kind increases the oscillation of eyeballs. On examination by ordinary light, the interior of eye can readily be made out. The mother had nothing to say regarding prenatal impressions of any sort. There are four children in family, and these are second and third. Dr. Wood said the question was, how should their eyes be treated?

DR. KENNEDY thought colored glasses, by absorbing some light, would be useful.

DR. HY. HOWARD had seen several similar cases. He used to treat them successfully by using ordinary colored glasses covered with chamois leather, leaving a slit-like opening in the middle of the leather.

Double Nipple.—DR. CAMPBELL mentioned having lately seen a man with two nipples on his left side, and said that Dr. Howard of Lachine had recently seen a case of double nipple on each breast.

DR. SMITH had seen a similar condition in a woman.

Traumatic Delirium.—DR. HINGSTON mentioned that lately he had had an unusual complication follow several operations, viz., violent delirium, with high temperature, lasting four or five days, but never ending fatally. Some of these cases occurred in private practice, others in hospital, and all in temperate patients. He asked if any of the members had similar cases.

DR. TRENHOLME said he had seen several cases of high temperature, accompanied with delirium, follow delivery at the Western Female Hospital.

Condolence.—The following resolutions of condolence were passed :—

Resolved,—That the members of this Society have heard with deep regret of the death of Dr. John Reddy of this city, which took place in Dublin on the 23rd January. The Medico-Chirurgical Society of Montreal feels that in the death of Dr. Reddy, one of its former Presidents, it has lost a member of the profession who, in his entire work, proved himself to be devoted to its best interests.

Resolved,—That this Society extends to the family of the deceased its deep sympathy in the bereavement which has befallen them.

McGILL MEDICAL SOCIETY.

The seventh regular meeting for the session 1883-84 took place on January 12th, 1884. Dr. Stewart read a paper on "*Some points in the Diagnosis and Treatment of the Neuroses of the Genito-Urinary Organs.*"

The eighth regular meeting took place on Jan. 26th. Dr. MacDonnell read a paper on "*The Human Hand*," and Mr. W. G. Johnston reported a case of *Cardiac Dyspnœa*.

The ninth regular meeting took place on Feb. 16th. Dr. J. A. MacDonald read a paper on "*Renal Calculus*," Mr. W. G. Johnston exhibited some pathological specimens, and Mr. Darey reported a case.

The tenth regular meeting took place on March 1st. Dr. R. J. B. Howard read a paper on "*Defœcation*," and exhibited a specimen of an *os centrale* in the human carpus.

J. H. DAREY, *Secretary*.

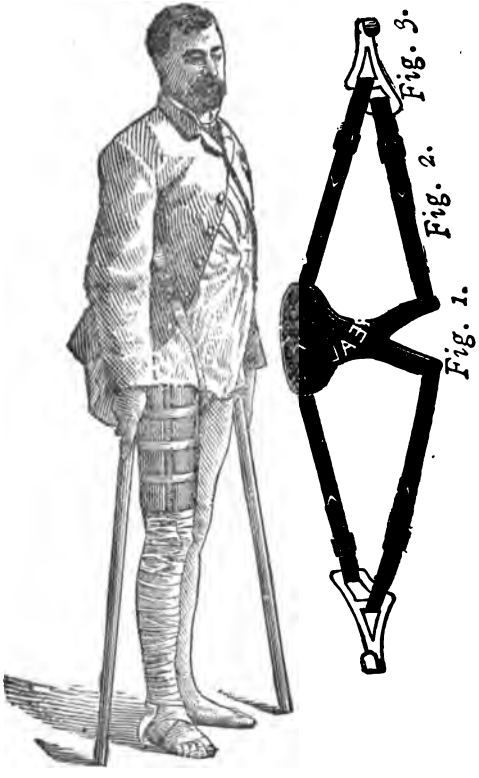
Extracts from British and Foreign Journals.

Unless otherwise stated the translations are made specially for this Journal.

New Form of Saddle-Crutch.—We publish by request the following description of this new mechanical support, which first appeared in the *Journal of the American Medical Association*, September 1st, 1883:—

When the patient has recovered sufficiently to leave his bed, crutches are found to be necessary to enable him to move about for exercise and for other purposes; and if you look at the Plate

Plate VI.



you will see a good representation of a saddle-crutch which I invented some time since, and which has given a number of

my patients a great deal of comfort and myself much satisfaction. The saddle and suspenders are worn inside of the clothing, the hooks alone coming out two inches below the axillæ. Ordinary sticks of proper length suit quite well for crutches if the top end is chiseled to fit the hooks of the suspenders, as they do not touch the axilla when the patient is suspended upon them. Thus the body can be maintained in a natural posture both while standing on the feet, while sitting on a chair, and while swinging in the act of stepping. I will mention two cases:

Mrs. G., a lady of two hundred and ten pounds weight, came under my care last winter with fractured fibula. When the proper time had arrived I ordered crutches, as usual. Their use was attended with so much suffering, she being afflicted with prolapsus uteri, that she was indisposed to take necessary exercise. I then had a saddle prepared for her, and nicely padded to fit. This she used during the period of convalescence without discomfort, walking three or four hours every day. After she gave up using it, it was re-covered with soft leather and sent to me. It had proved such a pleasant support for her that when her limb was quite restored to usefulness she abandoned the use of the saddle with regret. I pass it round that you may see how it is padded to suit the circumstances.

Mr. B., a gentleman of two hundred and thirty pounds weight, with a similar injury. On the ninth day he procured a pair of crutches, but he got along rather poorly with them. I lent him a saddle, and from that time until he got quite well he used it constantly. It is not necessary for me to explain the advantages of carrying the weight of the body upon well-cushioned pelvic bones fitted by nature for the purpose. Neither do I feel called upon to point out the inconvenience and suffering imposed upon a patient when the doctor orders him to take exercise with ordinary crutches, with the weight of his body suspended upon cross-heads in the axillæ, where he is also in constant danger of injury to the vessels and nerves contained within their boundaries. These are obvious to you all without further mention. The saddle is of simple construction, and can be made very cheaply. I use a bit of steel cut to shape and

bended into the general form of a saddle. A few holes are drilled in to fasten the padding, and a little rivet on each corner, with a protruding head like a button, to fasten the suspenders to. The straps and hooks can be made of any material that is strong enough to carry the body and to suit the pocket or taste of the wearer. I use the boot-strap webbing one inch wide, with button-hole on one end and a buckle near the other end, so that they may be shortened or lengthened at pleasure. Leather straps answer the purpose. The hooks can be made of thick wire bended to suit. I use thin steel plate cut to shape and bended as required.

Torture and Sexual Excitement.—The relation between certain auto-mutilations and sexual excitement was long ago remarked by Montaigne, who said that "lust seeks self-stimulation even in pain." It has been noticed that hebephreniacs often mutilate themselves, not from a sense of penance, but with obvious enjoyment. Dr. G. M. Cox (*Alienist and Neurologist*, April, 1883) cites an instance of the relation of these seemingly opposed agencies. The victim was a man—who had a wife and several children—of good character, and otherwise sound mentally, but who, at stated periods, displays certain peculiarities. He has never been known to cohabit with a lewd woman nor to speak an immodest word; yet he is a regular visitor and, in his way, a liberal customer of houses of ill-repute. He goes early in the afternoon, selects two of the largest girls in the house, repairs to a private room, and locks the door. He divests himself of all his clothing, except his trousers and boots. Then, lying on the floor, he commands his companions to walk over his naked chest, neck and face, taking care to stop and grind his flesh with their boot-heels. He then buys wine for his tormentors, but drinks none himself. This system of self-torture goes on for a couple of hours. It is said the ecchymosis thus produced soon disappears. The peculiar satisfaction experienced by the "flagellants" was evidently of an unrecognised sexual origin, and the subject needs investigation.—*Journ. of Nerv. and Ment. Dis.*

Antiseptic Puerperal Dressing.—Dr. Garrigues says:—Having been asked by several practitioners how I arrange the details in private practice, I will give the particulars here. I carry powders of 15 grains of corrosive sublimate in my satchel, in order to be sure to have them on hand. After confinement I prescribe powders with 7½ grains. I dissolve the 15 grains in a quart of hot water, stirring with a wooden spoon. This forms a solution of about 1 to 1,000, which, according to circumstances, is mixed with an equal amount of hot or cold water, thus forming a solution of 1 to 2,000, which is the strength used for all purposes. I dispense with the disinfection of the abdomen, thighs, and buttocks, deemed necessary in the hospital, but inject invariably a quart into the vagina, placing the patient on a bed-pan. If the latter utensil were not obtainable, it might easily be replaced by some contrivance which will present itself to the mind of the practitioner. In tedious cases I repeat this injection according to circumstances, at least once in three hours, in which case it serves both as a disinfectant for the vagina and as a stimulant for the uterus. When the presenting part appears, I apply to the vulva a piece of lint dipped in the solution, except, of course, in precipitate labor. After the birth of the child and the removal of the after-birth I wash the patient with the solution; apply a binder; cover the genitals and anus with a piece of lint, wrung out of the solution, eight inches long, and folded so as to form four layers three inches wide, which is exactly the width of the space between the genito-femoral sulci in most women; place outside of the lint a piece of oiled silk which is an inch longer and broader; put a large pad of carbolized cotton on top of the oiled silk, and fasten the whole tightly to the binder. For the binder and this piece between the legs I prefer Canton flannel, but any clean muslin or linen will do. The principle in this bandage is to have an absorbent wrung out of the solution of bichloride of mercury in immediate contact with the genitals, a waterproof substance outside, in order to prevent the bichloride from being absorbed by the external parts of the dressing, and a dry and soft absorbent outside the waterproof material, in order to take up the

discharge which exceptionally escapes from the inner compress, to form a first filter for the air, and to keep the inner compress in contact with the skin. Where strict economy is necessary, the lint may be replaced by muslin or cotton batting, the oiled-silk by gutta-percha tissue, and the carbolized cotton by common cotton or any clean rags. If the perinæum has been torn, it is stitched up before applying the bandage, but all other wounds are left entirely to themselves under the protection of the dressing. Three times a day the outside of the genitals and surrounding parts are washed with the solution, and the dressing is renewed. For this purpose the person in charge of the patient dissolves one of the 7½-grain powders in a quart of warm water. No trained nurse is required, the procedure being so simple that the husband or any female friend can perform it.

The simplicity of this treatment is apparent; its safety for patients, nurses, and doctors is demonstrated by the total absence of any kind of untoward accidents during the five months it has been in use; and its efficacy is proved by the radical change in the condition of the patients in an hospital that abounds in unfavorable hygienic features, and in which disease used to be permanent and death frequent.—*New York Medical Journal*, March 1, 1884.

The Contagiousness of Phthisis.—One of the evil results of the recent discoveries concerning the nature of tuberculosis has been the strengthening of previously only vaguely entertained suspicions of the contagiousness of phthisis. Since it has been conclusively shown that, with tuberculosis, there is found associated a micro-organism, many have rushed to the rash conclusion that it must of necessity be contagious. Others have even gone so far as to insist upon the strict isolation of all consumptives. But while it is true that the disease may, under certain circumstances, be communicated from the sick to those about them, every day experience teaches us that such occurrences are exceptional, and certainly far too rare to justify the cruelty of excluding such poor sufferers from grateful companionship with their fellow-creatures.

It is quite pertinent to refer here to the work done by the Collective Investigation Committee. Concerning it the *British Medical Journal* says; "A large amount of impressive evidence is forthcoming, that persons who are free from hereditary predisposition may acquire phthisis by being brought into very close personal contact, and especially from sleeping with phthisical patients; but the precise conditions under which the disease is communicated have yet to be studied. While this is perfectly true, it must also be remembered that communication is rather the exception than the rule, and that, while it suggests the precautions of good ventilation, disinfection of air and sputa, and separate beds, sufferers from this disease may be tended with comparatively little risk."

It may also be of interest in this connection to allude briefly to the results of some experiments recently undertaken by Drs. Celli and Guarneiri, and published in the *Gazetta degli Ospitali*, No. 56, 1883. These investigators were unable, after the most careful search, to find tubercle bacilli in the air of an unventilated room in which phthisical patients had been sleeping. The expired breath of these patients was likewise found to be entirely free from bacterial contamination. Nor could the specific micro-organisms be discovered in air which had been passed through the sputa of tuberculous patients, although in every case the expectorations were found to contain them in large numbers. They were also unsuccessful in attempts at inoculation with fluids impregnated with this presumably vitiated atmosphere. It would thus appear that the fears of those who lay too much stress on *a priori* reasoning and too little on the facts of common experience, are to be treated as an exaggeration of morbid apprehensiveness.—*N. Y. Med. Record.*

New Views on Bright's Disease.—At a reccent meeting of the Académie de Médecine of Paris, Prof. Semmola, of Naples, communicated to the Society the result of his latest experiments on Bright's disease, under which term he understands chronic parenchymatous nephritis only. The primary cause of albuminuria in that disease is, according to

some, a lesion of the kidneys themselves, while others explain it either by a pathological condition of the albumen in the blood, or by a combination of these two causes. Semmola's experiments go far to show that the lesion in the kidneys is a secondary process. He injected daily under the skin of dogs ten to seventy grammes of white of egg; after four to five days, there were signs of a congestion of the kidneys, which led to hæmorrhage when the dose of albumen was large. After seven to ten days, leucocytes were found in the urine, and the renal epithelium, began to show signs of fatty degeneration. This, after a fortnight, was well marked; and about the twenty-fourth day, there was evidence also of an interstitial lesion of the kidneys. The introduction of albumen into the blood produces a peculiar dyscrasia, and the quantity of albumen eliminated by the urine is larger than that which has been injected; in the animals experimented upon, the bile contained albumen, which is also the case in patients suffering from Bright's disease. As for the cause of the peculiar dyscrasia alluded to, Semmola thinks that it is an alteration of the nutritive functions of the skin. He tried also the subcutaneous injection of blood-serum, yolk of egg, and milk, the first caused a slight albuminuria, but the last two had no effect.

Cider and its Anti-Calculous Properties.—A writer in the *Gaz. Med. de l' Algerie* calls attento a recent publication by a pupil of Dr. Denis-Dumont, surgeon-in-chief of the Hotel-Dieu, of Caen, which professes to demonstrate that cider is the enemy of stone in all the varieties of calculi which, from one cause or another, affect the bladder. During a long experience in the hospitals of Caen, Dr. Denis-Dumont was struck with the almost complete absence of patients affected with stone—almost complete, because there were a few cases whose habitual beverage was wine. On treating these cases with cider, they were either considerably benefited, or entirely relieved of their malady. Struck with these facts, Dr. Denis-Dumont entered into correspondence with a large number of the medical practitioners of Normandy, principally those who

practiced in localities where cider was the common and almost sole beverage. Of these practitioners, some of whom were of forty years' experience and longer, none had treated a case of stone. If they had treated any affection allied to stone, it was in cases where cider was not the ordinary drink, or it was due to some foreign cause. As a consequence, he has collected a mass of valuable observations which confirm his conjeetures, and support him in formulating the proposition that cider is not only a prophylactic against the formation of stone and other affections of the bladder, but also that it is an energetic curative agent, when in the condition to be absorbed, like any ordinary drink, and brewed in the best manner. Cider, even in Normandy, is frequently improperly made—but it would seem that bad cider is not worse than bad wine. The writer, using the precaution to declare that he is not of Normandy, goes on to say, with the effusion of a Frenchman, that, if the results of Dr. Denis-Dumont are admitted, they will furnish cause enough for the encouragement of plantations of apple-trees, and for the fabrication of a beverage which laughs at the phylloxera, which has been served on the table of a Queen of France, to Saint Radegonde, which Charlemagne did not despise; which was celebrated after the epic mode in a Latin poem dedicated to the glory of Phillippe-Augustus by Guillaume le Breton, and which Francois the First appreciated on his visit to Normandy.—*Ex.*

General Anæsthesia by Insufflation of Carbolic Acid in the Larynx.—Brown-Sequard states (*Societe de Biologie*) that the insufflation of carbonic acid into the superior part of the larynx will cause anæsthesia not only of the organ, but a general anæsthesia, in five minutes. This is not the consequence of a local effect, but of absorption of carbonic acid in the lungs. It is an act of inhibition. resulting from the irritation of the laryngeal nerves, which manifests itself through the intermediation of the nerve-centres; in fact, a previous division of the laryngeal nerves prevents the production of anæsthesia. When only one of the laryngeal nerves is cut, anæsthesia is manifested in the side

corresponding to the divided nerve. When general anæsthesia is tardy in production, it suffices to bring it about by a more energetic insufflation. Sensibility returns rapidly in some parts, slower in other parts, and latest in the parts nearest the larynx. Brown Sequard has long since found out that epileptic seizures can be promptly suppressed by the injection of an energetic current of carbonic acid into the larynx.—*St. Louis Med. and Surg. Journ.; Maryland Med. Journ.*

Rheumatism and its Allies in Childhood.—Dr. Thomas Barlow thinks that it is impossible to define systematically what is meant by rheumatism, and at present it is best to agree on what we consider to be a typical case of rheumatic fever, and to study the subsequent relapses, sequelæ, and recurrences of that affection. Attention is drawn to an affection about which there is much difference of opinion—viz.: scarlatinal rheumatism. Rheumatism is often spoken of as a sequela of scarlet fever, but it is more often a complication than a sequela. Often in scarlet fever swellings in the sheaths of the tendons are noticed, and joint-structures become implicated; these symptoms subside very rapidly under the influence of salicylate of soda. In rare cases the effusion in one joint at least becomes purulent. There is also in scarlet fever sometimes an affection of serous membranes parallel to what is found in rheumatic fever, but in scarlet fever these effusions often become purulent. Speaking of skin-lesions in relation with rheumatism, the author does not consider that erythema nodosum is closely related to rheumatism, much less convertible into it; but with regard to erythema marginatum and erythema papulatum, there seems more satisfactory evidence to prove that they are related to rheumatism. Urticaria and purpura are in rare instances also related to rheumatism. Dr. Barlow thus sums up his remarks on the relation between chorea and rheumatism: 1. Chorea should be looked upon as a symptom rather than a disease. 2. We are no more justified in saying that chorea is always rheumatic, than in saying that delirium and hyperpyrexia are always rheumatic. 3. Chorea occurs so

frequently in connection with rheumatic symptoms, both in combination and in alternation, that we are justified in provisionally regarding it as itself often a rheumatic symptom. Salacin compounds are not often of much use in the rheumatism of infants, as these compounds are most useful in cases of joint-effusions with pain and fever; whereas a great deal of the rheumatism met with in children is insidious, being attended with ill-defined joint-affection, slight pain, and fever.—*London Medical Record, December* 15, 1883.

A Ready Means for Removing Foreign Bodies from the Throat.—Dr. M. A. Veeder, of Lyons, N.Y., says: "A loop of ordinary suture wire, which may be readily bent in any shape desired, forms an available means of hooking such as pins and needles out of the throat, and has the merit of succeeding sometimes where more elaborate contrivances have failed."

To Check the Secretion of Milk.—Dr. Verrall (*Brit. Med. Journal*) recommends iodide of potassium, 8 grains, and quinine sulphate, 23 grains, three times a day.

Medical Women in the Olden Time.—It is not only at the present time that the Hippocratic art numbers its disciples among the female sex; for the *ancien regime* was quite familiar with the professional equality which the press of our day chronicles as a novelty. For example, we have only to consult the *Calendrier Historique de la ville de Lyon* for 1735, to find at the end of a list of the 43 *maîtres chirurgicus*, and preceding that of the apothecaries, a list of 13 widows of surgeons. It would appear that at that period it was admitted that professional knowledge could be transmitted by cohabitation, inasmuch as these widows had the right to practice after the death of their husbands.—*Lyon Medical*, Jan. 13.

CANADA

Medical and Surgical Journal.

MONTREAL, MARCH, 1884.

THE STUDY OF ANATOMY.

The session of 1883-84 has now come to a close, and as it is the first since the introduction of our New Provincial Anatomy Act, we may be permitted to enquire what has been accomplished by it. The first noticeable fact is that, from last October until the present moment, not one single paragraph has been found in the daily papers having reference to the desecration of graves. It will be remembered that, in former years, complaints were numerous and the excitement of the public on the subject intense. We have, moreover, been informed by the teachers of anatomy that it is their belief that, for the first time in the history of the country, grave-robbing has been entirely unknown. The main object, therefore, for which the Act was passed—viz., the suppression of the resurrectionists—has been completely fulfilled. At the same time, the requirements of the Medical Schools have been amply met, so that, instead of restricting students in their practical studies, much larger classes than usual have been supplied with as much dissecting material as there was demand for. It would therefore seem evident that the Act has proved itself a good and efficient one. All public scandal has been avoided, and no real case in which the provisions of the Act have borne harshly upon members of the community has come to light. To all reasonable people these facts should be sufficient, and any fears concerning the possible ill effects of such legislation ought to be dispelled. Instead of being thankful, however, for this measure, which has been the means of doing away with a source of perpetual irritation, disgrace and disquietude, certain people

are even now trying to keep up an agitation on the subject started some time ago. Two of our daily papers have been lending themselves to this unwise opposition. They do not adduce cases of real hardship—cases where the feelings of friends or distant relatives have been wounded by the enforcement of the law. They cannot, for the law has been very carefully administered, and under the supervision of the competent inspector, such possibilities are carefully guarded against. Their arguments are based upon purely hypothetical cases, and upon these they call for agitation for a repeal of the Act. We think this unfair. Take fairly the facts as they exist. Much good has been done; the country relieved of a great incubus of dread and fear of graveyard desecration: the *morale* of all students improved by the removal of a stain upon their name: teachers relieved from a horrid and secret traffic in bodies with midnight marauders. Against this, we know of no substantial case of outraged relatives crying out against a real injustice. Influential papers should think twice before adopting a course so opposed to a real reform. The strangling exploits of Burke and Hare are not yet forgotten; the horror of the events with which these names must always be associated led to the passage of Acts like this for the supplying of the Medical Schools of Great Britain: since when people's minds have been at rest. History repeats itself. In many States of the Union there is no Anatomy Act. The inevitable consequences have followed. Last year we had the scandals in Philadelphia concerning the sale of bodies to the schools by a bribed guardian of the cemetery. This year we have what will long be known as the "Avondale murder." In Cincinnati, the schools had great difficulty in procuring bodies, and the demand was urgent. Two negroes, already versed in the traffic, proceeded to a secluded cottage where dwelt an aged man and two younger people. They attacked and beat to death these three unfortunates, conveyed the corpses to the Ohio Medical College, and sold them to the Demonstrator of Anatomy. "No questions asked." They set fire to the house, which was entirely consumed. Suspicion was aroused by the fact that not a vestige of the three persons was discovered in the ashes; search

was made, and they were at last discovered in the Medical School. The murderers have confessed, and await trial. This awful and truly diabolical triple murder is clearly the outcome of the supineness of the State in not having made proper provision for that which is an admitted necessity in every civilized community, and the responsibility for which the people everywhere recognize as falling upon the governing body. Do we wish to revert to a state of things which would permit of the possibility of the re-enaction of such a horrible tragedy? We sincerely hope not, and we think all medical men should impress upon their lay friends the necessity of giving a fair and reasonable trial to the present Act before condemning it. Let those opposed to it only wait, we are convinced they will find their fears groundless, and that after a time they will fain admit that the law is good and has truly been made in the best interests of the State.

We may mention that Ontario is moving in the direction of enacting an Anatomy Act similar to that of the Province of Qnebec. We trust their Legislature will see the wisdom of passing such a measure.

PROPOSED SANITARY BUREAU.

A meeting of medical men took place on the 4th, at Ottawa, in the Railway Committee Room of the House, for the purpose of considering the question of a Dominion Sanitary Bureau. Most of the professional members of the Senate and Commons and fourteen or fifteen of the local physicians.

DR. BERGIN, M.P., took the chair, and DR. PLAYTER acted as secretary. Dr. Playter proposed the following plan;—

It is proposed that in accordance with the present arrangement of the departments, a Sanitary Bureau be associated with the Department of Agriculture. That the Minister of Agriculture be also Minister of Public Health in all such matters relating to the public health as come within the supervision or jurisdiction of the Federal authority, such as vital statistics, quarantine, etc. That there be a Deputy-Minister or Superintendent of the Sanitary Bureau, who shall be a medical man,

appointed by the Government, and who shall be practically chief sanitary officer of the Dominion sanitary system. That there be a permanent Sanitary Committee associated with the Sanitary Bureau, which shall consider and discuss all matters coming within the province of the bureau, and all matters pertaining to the public health of the Dominion, and which shall confer with and advise the Minister and chief sanitary officer in all such matters, and consider what legislation, provincial and federal, will best promote the public health. The Sanitary Committee to consist of a certain number of members, one at least of whom shall be from each of the principal provinces. That the Sanitary Committee have a chairman and secretary, appointed as such by the Government and to be medical men; the Minister and deputy or superintendent of the Sanitary Bureau to be *ex-officio* members of the Sanitary Committee; the Sanitary Committee to meet at certain times in the year in Ottawa for the consideration of such matters relating to the pnblic health of the Dominion as they shall think most desirable; the chief sanitary officer and the secretary of the Sanitary Committee each to receive a salary, but only travelling expenses and per diem honorarium while engaged on the duties of the committee to be paid to the other members of the committee; that there be appointed by the Government in various localities throughout the Dominion a number of local sanitary officers, who shall be medical practitioners, and who with the committee and officers before above named shall constitute the sanitary system of the Dominion; every local sanitary officer is to send to the department at Ottawa, on the first day of every month, a report or statement of the nature or kind, extent and course, so far as could be by him obtained, of any epidemic or epidemics of infectious disease that had prevailed in his locality during the previous month, and such information concerning the general condition of the public health therein as he may be able to obtain, or as may be determined upon by the Sanitary Committee; each local sanitary officer shall be paid for each and every such report or statement the sum of $2; as the present system for the collection of mortuary statistics is enlarged

from time to time, these local sanitary officers may become statistical officers of their respective localities for making correct returns of deaths to the departments; and on the outbreak of any epidemic of infectious disease in any locality, the local sanitary officer of such locality may, at the request of the chief sanitary officer, make investigation into the source, origin, or cause of such outbreak. The department to issue for free distribution, early in each month, a report containing the synopsis of the reports received from all the local sanitary officers, and any other sanitary information for the public that may be deemed advisable by the Sanitary Committee; and that it shall issue an annual report.

The probable cost of the whole system per year would be about $10,000 or $11,000, a very moderate sum for a Dominion health bureau.

Hon. Senator ALMON said he had examined the plan before the meeting, and thought it all that could be desired to commence with.

DRS. GRANT and ORTON spoke strongly in its favour.

DR. POWELL asked if it would not be well to learn first if the Government would entertain the acceptance of any plan at present.

DRS. SPROULE and ORTON believed from what the Government had stated that if the members of the House and others could decide upon some plan, the Government would endeavour to have it carried out.

Hon. Senator PAQUET thought it would not be well to delay, something had better be done now.

DR. HICKEY suggested that the meeting discuss the plan in detail, but as all present had had each a copy of it, it was thought this would occupy too much time.

It was at length moved by Dr. ORTON, seconded by Dr. CHURCH:—That in the opinion of this meeting it is desirable that a Dominion Health Bureau be established and associated with one of the Departments of State in Ottawa.

Carried without opposition.

Moved by DR. ORTON, seconded by DR. HICKEY—That the

following be a committee to wait upon the Government with the plan under consideration, and ask the Government to provide means to have it or some similar plan carried out, viz. :—Hon. Senator Dr. Paquet, Drs. Grant, Bergin, Church, La Rocque, and the mover and seconder, Drs. Orton and Hickey.

Carried without opposition.

SOMETHING NOT GENERALLY KNOWN TO SURGEONS.

The following cutting from *Wilford's Microcosm* for February will be another argument in favour of "Resurrecting," and will also show how the science of the 19th century is pervading all ranks of the community! What next?

SENSATION IN AMPUTATED LIMBS.

Ed. Microcosm.—In Louisiana, Pike Co., Mo., lived a few years ago, a celebrated surgeon, Dr. Bartlett. His son related to me the following:—Dr. Bartlett was very suddenly called upon to amputate the fractured or broken arm of Mr. Stark, Sheriff of the County of Pike. The broken arm was nicely amputated, and by the friends buried as is customary in such cases. Mr. Stark complained very much of great pain in the small finger of the buried arm or hand. The Dr. (Bartlett) was called in. He (the Doctor) believed that such suffering might possibly be caused by an improper burial of the amputated part. So he took up the hand (arm), straightened out the little finger and placing cotton nicely between the fingers, he re-buried the arm very carefully, and there was no more trouble or pain suffered by Mr. Stark. These are the facts in the case. Dr. B. is known as a first-class surgeon, and as a man whose statements are not called in question. Yours truly, J. B. BRADLEY.

REMARKS ON THE FOREGOING.

Professor Bradley, of the Christian University of Canton, Mo., is not the man to state such facts as the above unless he had quite reliable evidence as to their correctness. We have in former volumes printed several statements of similar facts from reliable sources, and have called upon scientific thinkers and

investigators for an explanation. If the incorporeal organism in man is a real substantial entity, and the exact counterpart of the physical structure, as Substantialism teaches, this certainly would suggest an explanation. The amputation of the physical arm does not, according to this view, take away entirely the incorporeal arm whose form remains connected with the living body. Yet it does take enough of such incorporeal arm to retain its form also in the severed limb, and thus keep up a sympathy between the two till decomposition in the buried arm takes place. Who can offer a more rational solution ?

VERMONT MEDICAL COLLEGE.—The opening exercises of this school took place on the 6th ult., and were of a special nature, inasmuch as the University had been made the recipient of a splendid gift of a new building for the Medical Faculty, which is now ready for occupation. Judge Wales, on behalf of the donor, Mr. John P. Howard, made the formal delivery of the building to President Buckham, who made a suitable reply, and then handed the keys to Dr. Grinnell, Dean of the Medical Faculty. The Hon. Henry Ballard then delivered the dedicatory address. The new building is of brick, 50 x 90, and contains chemical and histological laboratories, a large dissecting room and a spacious theatre capable of seating 368 persons. We congratulate the Faculty on having secured such a suitable building.

HEALTH AND HOME: A JOURNAL OF SANITARY SCIENCE AND HOME HYGIENE.—We have received the first number of a new periodical with the foregoing title. It is to be edited by Mr. Fred. N. Boxer, of this city, who is well known as an active and advanced sanitarian. Mr. Boxer has already done good service in Montreal by exposing the entire absence of proper system in connection with the Health Department of the city, and by insisting, as a member of the Sanitary Board, upon the necessity for defining in the clearest manner the duties of all its officials. He has also been largely instrumental in the formation of the "Canadian Sanitary Association," of which he

is the Secretary and of which this publication is to be the official organ. It is not to be exclusively scientific, but will contain to a considerable extent reading matter that will render it suitable for general circulation. It is to be hoped that the dissemination of literature of this nature will serve to arouse in the profession and the general public increased interest in the hygiene of themselves, their homes, schools and public buildings. The Journal itself is very neatly gotten up, and the contents are suitable and varied, and the topics well chosen. We wish a long and useful career to "Health and Home."

THE TERM "PLUCKING."—At this season, when feathers are in the air, it may interest some unhappy candidates to know the origin of the term. In the "Notes and Reminiscences of the late Mr. W. H. Harrison," he mentions, in the description of a visit to Oxford, a custom in which it no doubt originated. He says, in describing the conferring of degrees: "I observed that one of the proctors who sat by the Vice-Chancellor when a passed undergraduate was proposed for his degree, left the side of the Vice-Chancellor and walked down the line formed by the 'heads of the houses,' and then, returning, resumed his seat. Dr. Bliss explained this by saying that in former times, if any one of the 'heads of houses' plucked the gown of the proctor it barred the degree. And this he might do without assigning any reason; but if he did so a second time, his reason was challenged. And this is the origin of the term 'plucking.'"

— We have much pleasure in congratulating our friend Mr. H. R. Gray, pharmacist, upon his election as alderman for St. Lawrence Ward. Mr. Gray conscientiously refrained from taking any personal part in the canvas, and yet has been returned by an overwhelming majority. This speaks volumes for the respect and esteem entertained for the new alderman by his fellow-citizens. We can only say we wish the City Council contained more like him. It is said that Alderman Gray will be put upon the Board of Health. In this capacity he will have full scope for the exercise of the many talents his friends know him to possess, and we trust his presence there will aid in bring-

ing about a new era in the administration of our civic sanitary affairs, for it is notorious how deplorably deficient these are.

Prof. Archibald, of McGill College Law Faculty, has also been elected Alderman for St. Antoine Ward. The upright character, wide learning, and high attainments of this gentleman will no doubt prove of eminent service in the councils of our city.

Medical Items.

AN OLD DEFINITION OF THE MEANING OF "DOCTOR."—A. Cresswell Rich writes to the *British Medical Journal:* The following epigram appears at the end of the preface to "The Practice of Physic," by Lazarus Riverius. From my study at Montpelier, July 1, 1653. It is signed "W. R.":—

> "*Doctors*, or *Teachers*, they of *Physick* are
> (Whether by Pen they do it, or in Chair,
> With lively Voyce), that teach the way to know
> *Man's Nature*, *Health* and *Sickness*, and do show
> *Diseases*, *Cause*, and *Cure*. But they who spend
> Their Life in *Visits*, and whose Labours end
> In taking *Fees*, and giving *Paper-scrowls*,
> FACTORS of *Physick* are; and none but *Owls*
> Do count such *Doctors*, that *no Latin* know,
> From whence that *Name* did to our Language flow.
>
> W. R., Doctor, and Factor of Physick."

—In Manchester, Eng., a druggist dispensed "three pennyworth of quicksilver and three pennyworth of aquafortis" to a man who wished to mix them to make some sort of an ointment. The man had bought these articles before, but they had always been put up separately. On this occasion they were put in the same bottle, which the man placed in his breast pocket, and left the shop. Very soon the bottle exploded, burning his face and eyes so seriously that he died at the Manchester Eye Hospital.

Maltopepsyn.—Since its introduction into the Dominion of Canada, some four years ago, Maltopepsyn has met with a constantly increasing demand. This has no doubt been to a great extent created by the support of the medical profession. It is also said to be gaining ground in Great Britain, and to have been received there with much favor. It continues to sustain its reputation for the alleviation of digestive disorders and the cure of infants' troubles, such as cholera infantum, &c.

CANADA

MEDICAL & SURGICAL JOURNAL

APRIL, 1884.

Original Communications.

VALEDICTORY ADDRESS DELIVERED TO THE GRADUATING CLASS OF McGILL COLLEGE, 29TH MARCH, 1884.

BY GEORGE ROSS, A.M., M.D., Professor of Clinical Medicine.

Gentlemen-Graduates—A few words at parting are never amiss. If we have been permitted to guide and assist you in your studies for the past four years, that task is now accomplished, and our relative positions of teacher and student exist no more. That you have utilized the opportunities afforded you is proved by the possession of that parchment of which each has good right to be proud. It is the seal of your *Alma Mater*. She declares that you have faithfully served during the fixed time of probation—that you have shown that diligence which is absolutely essential for the attainment of knowledge—that your acquirements have been subjected to rigid and fairly critical tests—that, finally, you have been able to withstand the scrutiny of those very inquisitive persons, the examiners, and, therefore, she has granted you her *Testamur*. Wherever you go, you now have by you that which will always testify for you—that which will bear witness to your capability and fitness to be entrusted with the important duties and offices of the physician. I need not dwell *to you* upon *how* important these duties and privileges are. I believe that not one of you would be standing here to-day if he had not felt drawn towards this profession by a conviction of its intrinsic nobleness and dignity. Only this I might say, that the more a physician is imbued with a love of

his calling, the more frequently his mind dwells upon the abstract laws of cause and effect—the more satisfaction he feels in developing the power of tracing effects to their ultimate cause—the more he feels compelled to work on the sure foundation of science in this direction—the more real pleasure he experiences in succeeding in his search after truth (no matter how apparently *small* a truth)—the better physician he must be; and the better physician he is, the better man he must also necessarily become. Nothing can be more regrettable than the career of a medical man who casts aside all lofty aspiration or high aims connected with his profession, and contents himself with a daily toil of what then becomes an uninteresting routine. No matter how restricted may be a man's social or local advantages—no matter how isolated he may be—no matter how uncongenial his surroundings—no matter how discouraged he at times may feel—no matter how the world may treat him: yet, if he have a real, deep-down love for scientific work, he can make that work repay him for all, for it can make his life a life of pleasure, of animation, and of keen interest, in place of a life of care, disquietude, disappointment, and irritation with the world at large. Too many men, finding themselves, owing to circumstances, settled in some small locality, give themselves up to the monotony reigning around them, continue the jog-trot of a hum-drum existence, and leave this earth just no worse and none the better for their having occupied, temporarily, a spot upon its surface. This need never be. The problems of medicine and surgery are legion in number,—they lie open before us all, awaiting only the diligent application of our reasoning powers, upon accurately-observed facts in sufficient numbers, for their solution. It is true that the greater number of discoveries and advances in modern science and practical medicine have been made by the dwellers in great cities, men who devote their lives to special departments of enquiry and thereby acquire great learning and wisdom. But, admitting this, we should always remember that some of the greatest of all recent advances in our Art have been initiated and promoted by men living quiet and obscure lives until their great discoveries introduced them to public notice.

We have not far to look for illustrations of this fact. A plain, Kentucky doctor—his name was MacDowell—some years ago thought out the treatment of a form of dropsy which was called fatal. It was common, for thousands of victims died from it every year. He was the first to perform an operation for its relief. Thus was introduced one of the most successful of the operative procedures of modern times—one which, in the hands of men like Sir Spencer Wells, Dr. Keith and others, has been the means of saving many, many lives and relieving untold misery. Another of America's greatest men, one whose recent sudden death two continents still mourn—Marion Sims—initiated and advanced the great improvements which have made his name famous whilst still a mere practitioner in a small town in Virginia. True, such men as these would perhaps have compelled greatness anywhere: nevertheless, do not their lives show that professional work of even the very highest importance may be founded and completed along with the apparently commonplace duties of the general practitioner?

General practitioner—that is what most of you will necessarily become. It is only in large centres that the division into physicians and surgeons and specialists can be made. The general practitioner is sometimes apt to look with envious eyes towards his more favored brethren who have devoted themselves to a particular branch of medicine. But the general practitioner—the family physician—is the backbone of the profession. He may have a life more laborious and less freely rewarded than his neighbour the specialist, but never let him forget that his calling is equally respected, more responsible, and requiring the same talents for the full performance of its duties. Some think that this idea of dividing the field of medicine into separate departments is an invention of modern times. Not so, however. Herodotus tells us that amongst the early Egyptians the science of medicine was distributed into different parts. He says: "Every physician was for one disease not more, so that every place was full of physicians: for some were doctors for the eyes, others for the head, others for the heart, and others for occult disorders." Although generally admitted that certain special-

ties of the present day have done much to advance their own departments and science in general, yet it is thought by many that in numerous instances unnecessary divisions have been created, and that the future will rather show concentration of the offices than their multiplication.

We are often accused of being sticklers for etiquette. "Don't be so very particular," people will say when urging a line of conduct to a *confrère* which, in your opinion, verges upon the unprofessional. "Don't be so precise; just leave off a little of that straight-laced etiquette and no harm will be done." Never listen to them. They cannot be made to understand the real and good reasons underlying the excellent rules for our mutual guidance which have long been laid down by our foremost men and our oldest associations. Be quite sure of one thing, that a medical man, and especially a young medical man, always errs on the right side when he inclines towards a severe interpretation of the rules of conduct. Many are the specious arguments and the sophisms which will present themselves to you to help explain the reason why these rules may, in any given case or in general, be relaxed. There is no safety in listening to the voice of the tempter. To keep a clear conscience, you must do right and behave fairly, squarely, and openly to your professional *confrères* from the very start. This, on your part, may sometimes give offence, and perhaps stand in the way of your advancement or your interest. Never mind that. I have seen many a man cause himself infinite trouble and endless warfare with his neighbors by an early false step in this direction; but I never yet saw one who had reason to regret a firm adherence to a strict interpretation. No rules can be made to govern every case: no code of ethics can be complete. Aim at securing a conviction in your own mind that you have always been acting as one gentleman should act towards another. Then you cannot possibly go wrong.

At this season, when each of our colleges is adding its quota of graduates to a profession whose ranks may seem already full, one is apt to hear the commonplace remark, "There are too many doctors"; and to the tyro this is a discouraging sentiment.

But never mind. It is as true of Medicine as Webster said of the Law, "There is always room at the top." Aim, every one, at being one of the top-men. A good man—that is to say, in the sense in which we often use it, a thorough, capable and well-informed physician—will always find that there is a place for him, no matter where he goes. It is only the man who is content with a stagnant mediocrity who is heard complaining of overstocked profession, of want of appreciation, of the temptation to irregular practices, and of difficulty in maintaining strict professional relationship. He is the man who, on graduation, is amply satisfied with what he knows, and takes good care that he is not afflicted with any further burden of knowledge. High aims, a modest estimate of your own present attainments, and a constant desire to add thereto, united to perseverance, form together the only means by which you can hope to escape from the dangerous lethargy of a sleepy contentment. Amongst the men whose names at this moment (as always in the past) command universal respect in the profession, you will find no idlers: they are all workers, hard workers. Work, with a physician, must, to a large extent, signify and imply study. To impress upon you who have so recently been groaning under the heat and burden of the past session, with its climax in the fiery furnace of the examination-room, it may seem cruelty to urge the necessity for further similar exertion. Rather, just now, would you, with the wise king, exclaim, "Much study is a weariness of the flesh."

What shall I say upon the value of character to a physician? His good name is the breath of his nostrils. Of him more than of any other probably may it be said that, robbed of it, he is "poor indeed." A clean record, therefore, in all your relations with your patients and your *confrères* must be maintained with scrupulous and with zealous care. On this subject the following words from a recent American writer are most appropriate:—"It must be admitted that with professional men, the medical "man pre-eminently stands on his own acquirements and honor-"able conduct in life, and to him character is something that "cannot be over-estimated. The unworthy minister may be

" arraigned and refused the charge of a congregation, the lawyer " who acts dishonestly may be disowned by the bar and denied " recognition and standing in the Courts, but the medical pro- " fession has no such protection against offenders. The only " Court to which the medical profession can appeal is that which " is in perpetual session, the public, and in that court there is " no bar to recognition on account of conduct, character, or " acquirements. There each man stands for himself. He may " robe himself in the honorable name of the profession, and do " honor to it by his life, or he may dishonor it without being " arraigned or cast out. He may obey or disregard them, for, " in the view of that great court before which he practices, once " a doctor, always a doctor."

Cultivate, I pray you, the habit of a strict adherence to the real and true facts in all cases on which you give an opinion. We are all prone to error, even after having exhausted all our best efforts at arriving at a solution of some difficult medical problem. But on no account should we ever willingly distort the exact truth as it may show itself to us for any apparent advantage such would seem to afford. Yet, how often this is done! How notorious it is that certain individuals who are no credit to our profession make a constant practice of calling a mild and self-curable disease by some formidable name, that they may, upon recovery ensuing, receive from the *quidnuncs* all the credit of the cure. This point is thus forcibly alluded to in the recent Presidential Address of the New York State Medical Society: " When the pre-eminent importance of accurate diag- " nosis is considered, when the difficulties that environ its acqui- " sition are appreciated, when it is understood how patient and " enduring are the observations that lead up to the mastery of " the nomenclature of medicine, and the comprehension of the " varied conditions it represents, it is humiliating to hear the most " profound disorders that affect mankind bandied about in com- " mon speech as the veriest plaything of the hour. The diph- " therias that come into homes as plentifully as summer showers " over the landscape, and pass away as soon—the peritonitis that " disturbs the quiet of the night, and is dissipated with the

"morning dew—the pneumonia and spinal meningitis that early "recognition and prompt specific lead in a few days to vigorous "health, are all recounted, with flippant unconcern, in drawing-"room and social circle, in the highway, in the mart. These "are not the manufacture of the people, for the terms are foreign "to domestic culture. It were refined cruelty to charge upon "the doctor such consummate ignorance; better far, to credit "him with the knavery that can command untruth to advance "his interests or fortune."

There is one thing that no school can teach, no professor impart—a thing that time alone can give you. As time alone can mellow and impart a special flavor to the juice of the grape which no art can imitate, so only lapse of years can give to the physician that experience without which he is yet crude and untried. But why not avail of the experience of all those who have gone before? That cannot altogether be done. It has been very truly said that "neither nations nor individuals profit much by the experience of other nations and other individuals." And it is the same with the physician. Each must go through his experience for himself, "learning through suffering, succeeding through blundering, attaining to the calmness of wisdom through the pains of disappointment." But there are eyes and no eyes. Some men of half a century's practice are as devoid of experience, in the true sense of the word, as the beginner of yesterday: because, seeing, they see not. We hope that your training here has been such that you have acquired the gift of observation, and the habit of thinking upon what you have seen. If so, your success is sure.

Do you really know the nature of the life upon which you now are fairly launched? Theoretically, you do; practically, you will. No one will say that it is a life of ease, and as certainly it cannot be one of indolence. A physician's life is not to be judged of from the popular notions concerning it, but can only be understood from the words of one who has actually experienced its vicissitudes. We all have our trials, no matter how placed. Interference, silly suggestion, blame, calumny, preference given to the shallow pretender, are the least of these,

and the most easily borne. But who credits us with the awful responsibilities? Who takes into account the struggle of our failures? Who thinks of the wear on our sympathies? Who knows the humble toil, the physical labor, the mental strain of him whose name may be in every mouth in a metropolis? And the life of that most deserving and most hardly-worked of any of us, the country practitioner, what is it but toil, toil, especially if his field of work be some sparsely-settled portion of the country? This is the dark side. Is there not a bright one? Yes. The true physician is the welcome visitor, the one to whom all turn in trouble, and to whom family secrets are confided with the freest faith that they will be sacredly guarded: he is eagerly sought in hours of danger and anguish, confident that he has the power of relieving: he is the hope of many, the friend of all. This surely, spite of the hardships inseparable from it, makes a splendid calling.

But besides the individual benefits it is in the power of the medical profession to bestow, how many opportunities are open to its members for the advancement of the general community! The early studies of many will have imbued them with a love for natural science, and a pursuit of some of its branches may be both a source of great enjoyment to themselves and also of improvement to all those within their influence. The great movements for the amelioration of the well-being of places and communities must always command our sympathies, and some must always be led by medical men. Sanitation is a subject now assuming in every civilized country a national importance, and constant exertion is required to force our governments and legislatures to believe that its problems are deserving, even from the low standpoint of pecuniary economy, of the attention of the highest talent the country can produce. To aid in effecting this, individuals must be acted upon. They must be taught and made to believe (for, simple as it may seem, thousands *do not practically* believe) that pure water, pure air, general cleanliness, the prevention of decomposition, the stamping out of the germs of disease, affect him and his individually.

The physician, to be true to himself, must have *faith* in the

means he uses for combating disease. Hoffmann—he whose name attaches to the famous anodyne—says in one of his writings, "*Fuge medicos et medicamenta, si vis esse salvus.*" (If you would be whole, beware the doctor and his drugs.) Here is rank scepticism. Such scepticism it is too much the fashion of the present day to cultivate, admire and imitate. Pray do not be amongst those medicinal nihilists. Try to draw a line between the known and the unknown. Learn well what has been truly proven concerning the action of drugs. Observe in every case you can the exemplification of these actions. Thus you will come to feel certain of being able to produce a given result by the employment of a given remedy under given conditions. Thus you *must* have faith, and you can give a reason for the faith that is in you, and will not be driven about by every breeze of novel therapeutics, but holding fast to that which is good, will attack the enemy with weapons whose temper you know, and whose keen edge you are confident can be trusted.

The great desideratum for the student of the present day is practical instruction. Of theory, of didactic lecturing, of scientific courses, he gets galore. For the teaching of the actual matters pertaining to that art at which he is to work and by which he is to live he must trust to his hospital studies. No wonder that the most thoughtful often look back regretfully to the days when the old-fashioned system of apprenticeship was still in vogue. The actual and familiar contact of a man of experience with the novice, the imparting, day by day, of rules and observations gathered together in the mind of the teacher through many years of study and treatment of disease in its varied forms—this produced results of a practical nature very difficult to achieve at the present day. That most genial writer, the author of "The Autocrat of the Breakfast-table," in an address to his class, describes, in humorous fashion, a day's journey of Master Giles Firmin with his apprentice Luke. They go together a-horseback on a round of visits, and Luke stands by at each house and hears his master talk to the sick-folk and give his orders. When they are on the road again, Luke plies him with questions, to which grave and intelligent replies are given. In conclusion, Dr.

Holmes moralizes thus: "When I compare," he says, "the "direct transfer of the practical experience of a wise man into "the mind of a student—every fact one that he can use in the "battle of life and death—with the far-off, unserviceable 'scien- "tific,' truths that I and some others are in the habit of teach- "ing, I cannot help asking myself whether, if we concede that "our forefathers taught too little, there is not a possibility that "we may sometimes attempt to teach too much. I almost blush "when I think of myself as describing the eight several facets "on two slender processes of the palate bone, or the seven little "twigs that branch off from the minute tympanic nerve, and I "wonder whether my excellent colleague feels in the same way "when he pictures himself as giving the constitution of neurin, "which, as he and I know very well, is that of the hydrate of "trimethyle-oxethyle-ammonium ?"

Let me quote, in addition, the following further remarks of the same writer upon the comparative value of scientific knowledge and practical acquirements to the physician: "Medicine, "sometimes impertinently, often ignorantly, often carelessly "called 'allopathy,' appropriates everything from every source "that can be of the slightest use to anybody who is ailing in "any way, or like to be ailing from any cause. It learned from "a monk how to use antimony, from a Jesuit how to cure agues, "from a friar how to perform lithotomy, from a soldier how to "treat gout, from a sailor how to keep off scurvy, from a post- "master how to sound the Eustachian tube, from a dairy-maid "how to prevent smallpox, and from an old market-woman how "to catch the itch-insect. It borrowed acupuncture and the "moxa from the Japanese heathen, and was taught the use of "lobelia by the American savage. It stands ready to-day to "accept anything from any theorist, from any empiric who can "make out a good case for his discovery or his remedy. 'Science' "is one of its benefactors, but only one out of many. Ask the "wisest practising physician you know, what branches of science "help him habitually, and what amount of knowledge relating "to each branch he requires for his professional duties. He will "tell you that scientific training has a value independent of all

" the special knowledge acquired. He will tell you that many " facts are explained by studying them in the wider range of " related facts to which they belong. He will gratefully recog- " nize that the anatomist has furnished him with indispensable " data, that the physiologist has sometimes put him on the track " of new modes of treatment, that the chemist has isolated the " active principles of his medicines, has taught him how to com- " bine them, has from time to time offered him new remedial " agencies, and so of others of his allies. But he will also tell " you, if I am not mistaken, that his own branch of knowledge " is so extensive and so perplexing that he must accept most of " his facts ready made at their hands. He will own to you that " in the struggle for life which goes on day and night in our " thoughts as in the outside world of nature, much that he " learned under the name of science has died out, and that " simple, homely experience has largely taken the place of that " scholastic knowledge to which he and perhaps some of his in- " structors once attached a paramount importance." The tendency of all modern medical teaching is to decrease the amount of theoretical and didactic teaching and increase that which is personal and practical,—to replace the work of the lecture-room to a great extent by that of the Hospital, the Laboratory, and the Practical Anatomy Room,—to substitute for written and oral examinations upon given courses of lectures the far better tests of bedside diagnosis, of practical chemical analysis, and questions upon the cadaver. It is believed that this school is fully alive to the onward tendency in medical education, and will make ample provision for giving it effect.

I feel, gentlemen, that I have presented to you but a few meagre and disjointed thoughts suggested by the important events of this day. Be assured, however, of the fact that the interest of this Faculty in each one of you does not cease when you leave its halls. Your Alma Mater hears with keenest pleasure of the favor in which her children are held, and of the honors bestowed upon them in distant places: she mourns most sorrowfully over the faults and even sins of some, but garners carefully the good deeds of those whose lives shed lustre on her

name. Trusting that to you it may be given to add new laurels to those already won by many of your predecessors, I beg to wish you from myself, and on behalf of my colleagues whom I have the honor to represent, farewell and God-speed.

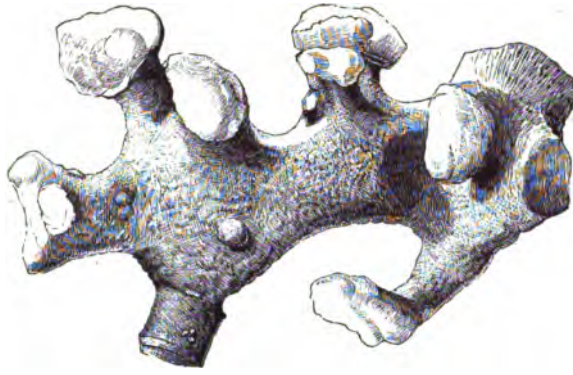
REMARKABLE CASE OF RENAL CALCULUS.

(With Engraving.)

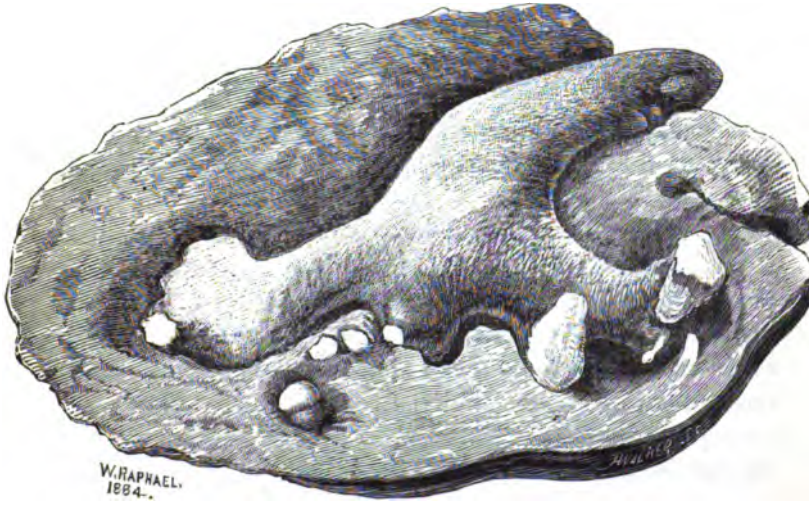
By. J. A. MACDONALD, M.D., Montreal.

Drs. Ambrose and Ricard, from whose patient the specimen was obtained, gave the following history :—

On the 29th of January, they were asked to see the patient on account of a very severe pain in the right lumbar region, which came on rather suddenly that day. The pain was so severe that an opiate was necessary. The patient was a stout, healthy-looking man, about 44 years old. Over 20 years ago he had suffered from a severe pain in the same region ; on this occasion he had been laid up in bed, was feverish, and lost flesh. He was then told that he had "fever." Was ill about six months ; recovered perfectly from the pain, and was free from it till twelve years ago, when he suffered from it more or less for two years. This attack did not interfere with his general health. From this time, had no return of it till the present attack. For over ten years has suffered slightly from palpitation of the heart on exertion, and his wife said his heart beat very strongly ; also suffered from occasional attacks of morning vomiting and greatly constipated bowels. For a great number of years, had to pass his urine once or twice during the night. Before this attack of pain he had been as well as usual. For the next four days he suffered severely. The pain was always strictly confined to the lumbar region, and was somewhat paroxysmal. No further symptoms were made out. The urine was not examined for albumen. On the morning of the 2nd February his physicians were sent for suddenly, and told that the patient had been returning to bed after having his bowels moved, when he was suddenly seized with an intense shortness of breath. They found him breathing very rapidly, quite cyanotic, almost pulseless, but quite conscious. He died about



LEFT.



RIGHT.

DR. MACDONALD'S CASE OF RENAL CALCULUS.

four hours from the onset of the attack, retaining consciousness to the last.

At the post-mortem examination, which was only partial (the abdomen alone being examined), the following condition of the kidneys was found :—Both appeared a little larger than usual; capsules easily removed; kidney substance quite healthy. In the left was a large calculous mass like a piece of coral; this mass entirely filled the pelvis, and branched out into the infundibula and many of the calyces. This stone is shown separately in the woodcut. The mucous membrane of the pelvis and infundibula was perfectly healthy. In the right kidney, the stone did not branch into so many of the calyces, but presented a long branch, descending about an inch and a half into the ureter. Mucous membrane healthy. This stone is shown in the kidney. There were no small stones in either kidney. The other abdominal organs were healthy.

This case presents the following exceptional points: 1st, The peculiarity of the calculi. 2nd, The almost entire absence of symptoms. 3rd, The healthy condition of the kidneys.

1st. Cases in which one stone has been found of this shape are not very uncommon; but that a calculus should form in each kidney and take on the form of the cavity of that kidney so exactly is certainly very rare. I have not been able to find any reported cases.

2nd. The only symptom in this case that could be referred to his renal disease was the pain in his loin, from which he suffered on three separate occasions. There was no history of renal colic or bloody urine. Of course, we would not find pus, as the man did not suffer from pyelitis. There are many cases reported of patients dying with renal calculi, and even with very extensive renal disease, and that in patients who were under observation, without their renal disease being at all suspected.

3rd. The most remarkable point about the case is that these calculi should have been present in his kidneys all those years without causing any destruction of their tissue. As you will see by this report, there was not even the slightest pyelitis. Renal calculi are far from rare, and stones of a much larger size than

this frequently found; but cases in which calculi of any size exist without more or less disease of the kidney are extremely rare.

In Vol. X. of the Transactions of the Pathological Society, Mr. T. Holmes relates a case of a very large calculous mass in one kidney, with very slight (if any) disease of the kidney itself. There was no history of renal disease; the urine contained no albumen. The patient died of an entirely different disease. This case approaches the one here related very nearly in many points,—the large stone, absence of symptoms, the healthy condition of the kidneys, and the death due to some other cause. But even here only one kidney was affected.

In Vol. XX. of the same Transactions, Dr. Church gives a case in which a small oxalate of lime calculus was found in the kidney of a woman aged 35. The kidney was quite healthy, and the only symptoms of the stone were pains in the loin during childhood.

In the museum of St. Bartholomew's Hospital are two specimens of renal calculi in almost perfectly healthy kidneys. One is the section of a kidney of a child five months old; the pelvis of the kidney is nearly filled by a calculus; the substance of the kidney is healthy. The other is a section of a kidney, with a calculus filling the pelvis and chief infundibula; the substance of the kidney is indurated, and its surface contracted.

From the foregoing reasons, the shape of the stone, the few symptoms, and the healthy condition of the kidneys, it is probable that the stones were formed very slowly, the process extending over a number of years, and thus the kidneys became gradually accustomed to the presence of the foreign bodies.

LETTER FROM STRASBURG.

(From a Special Correspondent.)

MR. EDITOR,—When one has seen Strasburg's famous Cathedral, its magnificent new fortifications, and its University buildings, he has seen all there is worth looking at in this quaint old city; but all these are scarcely equalled anywhere else in Germany. By planting a strong University, and by strongly garrisoning the city, the Government has taken the best possible means of thoroughly Germanizing this old Alsatian fortress. The population of the place, including the military, which swarm everywhere, reaches about one hundred thousand, but any slower, more old-fashioned city it would be hard to find. To me its University proved almost its sole attraction, and I shall try to show that it is one of the finest in Germany.

The new buildings, both those for pure science and those for medicine, are built in the most substantial, modern, and magnificent style of cut-stone. Those for science—the laboratories for chemistry, physics and botany being distinct buildings—are, indeed, palaces of learning. They are situated just on the outskirts of the town, in a fine open space, the grounds being in excellent order, while the botanical gardens, utilized for study, are an especial attraction. There are also several large greenhouses of handsome architecture, and a worthy astronomical observatory. The main building, in which the business departments, as well as some of the teaching, will find place, is a particularly imposing structure; its uppermost story being adorned on all sides by the most admirable figures, in stone, of the great men of learning of the past. Among these I espied that of Johannes Müller, and in the enthusiasm awakened by the memory of this the great, the greatest of physiologists, could scarce refrain from taking off my hat.

These buildings are all opened for the first time this year. The same may be said of some of those used by the Medical Faculty. The latter are in another part of the city—in fact, close beside the Hospital. The new Institute for Physiology is almost finished. Those for Pathology and Anatomy, and that

for Physiological Chemistry, were quite ready for occupation this year. The "Psychiatric clinic" is on the way to construction, but the Institute for Pharmacology is not yet begun. Experimental Physiology and Pharmacology are still conducted in rather poor quarters in the old building opposite to the Hospital entrance.

The "Bürger-Spital" is as old and as quaint-looking as the other buildings of the town; but its inside has been rendered tolerably attractive by the judicious use of paint, by good ventilation and scrupulous cleanliness. The floors are painted. The "surgical clinic"—or wards, &c., devoted to surgery—on the contrary, is new, elegant and modern in every respect. Strasburg has in all the Faculties about 900 students, and the Government has provided not only the finest of buildings, the best of apparatus, an ample library—in a word, all the *materia docendi*—but also professors, most of whom stand in the very front rank and several of whom have but few equals in the world. De Bary, the botanist; Fittig, the great chemist (organic); Hoppe-Seyler, the physiological chemist; Goltz, the physiologist; Von Recklinghausen, the pathologist; Kussmaul, the physician (kliniker); Schmiederberg, the pharmacologist. All these men stand quite in the front, and some have, perhaps, no equal. It will be noted that I mingle pure scientists and medical men together. This results partly from the high standing of the medical professors in Germany, and also from the fact that in Strasburg the University Society is called "*Der Naturwissenschaftlich-Medicinischen Verein.*" It is composed of two sections, the scientific and the medical, which meet on alternate Friday evenings. I was a very regular attendant, "as guest," at this Society, at which all the professors and all the assistants, as well as others, come together. The members of each section largely attended the meetings of the other, and with evident benefit, especially to the medical men. Such a Society is a prophylactic against narrowness. In neither section do the speakers use manuscript, mostly eschewing even notes, but they all make free use of the black-board (drawing), and occupy the attention of the meeting for generally one hour. As a rule, there is very little discussion;

however, as an exception, a very lively debate sometimes ensues. At a meeting of the scientific section, a privat-docent addressed the Society on some experiments he had been making upon "Color-perception in Insects." An animated, but perfectly good-natured, discussion ensued, in which the following professors engaged: Kundl, the physicist; De Bary, the botanist; Hoppe-Seyler, the physiological chemist; Goltz, the physiologist; Lacqueur and Stilling, oculists,—all mighty men of valor in the scientific world.

Among the subjects presented on different occasions to the meeting may be mentioned—(1), Mastoid Abscess and "Autophonie," by Kohts, aurist; (2) Ileus, &c., Kussmaul; (3) Paraldehyd as a Hypnotic, by Jolry, the psychiatrist; (4) Antisepsis, Freund. Before the scientific section, with many of the medical men present: (1) Influence of Warmth on Plants, by the Assistant in Botany; (2) Tree-cutting (Der Baumschnitt), Prof. Zacharias; (3) Paper-manufacture, by Rosl, chemist; (4) Bacteria, by De Bary, the botanist. Freund thought that sepsis was often effected in lying-in women by gases taken up by the vagina when sitting over a water-closet; he also thought there might be absorption through the vagina, &c., from the intestines. De Bary treated the bacteria question almost purely from a morphological point of view. He made reference to Lankester's (London) work, but scarcely mentioned Pasteur.

The attendance of the professors at the meetings of the Society is exceedingly regular. Nor are subjects of only a practical character brought before the medical section, but the contrary. Professor Solly, before, perhaps, the most crowded house of the whole semester, detailed results of his latest experiments on the cerebrum. Solly opposes the theories of Hitzig and Ferrier with the deepest conviction that they are baseless. His results are very striking, and I doubt if it is possible for any one to see Solly operate, remove a very considerable part of the fore brain, and then note the results in the dogs, and still believe in the Hitzig-Ferrier localization theories. There may be localization, and this Solly admits, but not as we have heard of it as yet. Many suppose the localization hypothesis derives powerful sup-

port from clinics and pathology—from symptoms and morbid anatomy. It is true that physiology may and has profited by the suggestions, the confirmations of a disordered system, but that clinics and pathology can *demonstrate* any physiological truth is very doubtful. By the most exact methods yet known to experimental physiology, there is room enough for fallacy, and as for the comparatively crude and imperfect methods of the clinics and pathology most nearly deserving the epithet scientific, we must be very much on our guard I venture to suggest. I cannot help thinking that not a few physiologists themselves fail to realize how many sources of error may interfere with their conclusions. A physiologist, above all men, needs caution. A few weeks after Solly's address, his first assistant, Dr. Ewald, demonstrated the action of some apparatus he had himself invented. One set especially seems worthy of attention. It was an arrangement by which slight variations (2 mm. of mercury) of blood pressure could be noted and recorded without opening the artery concerned at all. As is well known to experimenters, the clotting of the blood in all experiments involving the opening of the artery is a serious difficulty. By Ewald's apparatus, which was most ingenious, this is entirely obviated.

Von Recklinghausen, among other courses, gives what he calls a "demonstration course" twice weekly. All the specimens obtained in the dead-house in the intervening days are brought together, and being appropriately slit up and labelled, are placed on circular tin trays with narrow rims, then constituting "preparations." These are placed on tables brought end to end, thus forming two long rows. The observers sit on chairs opposite these specimens. The professor then delivers a two-hours' discourse on the material of the day, speaking a perfect stream the whole time. The specimens are passed from him to the students in order, and, at the same time, microscopic slides, to further illustrate the particular specimens, go from one to the other. The microscopes used are Hartnack's and Zeiss' ordinary powers; the specimens mostly stained with picro-carmine. This method, it will be observed by many readers, is substantially the one employed at McGill University in Montreal by Professor

Osler; the likeness being accounted for by the fact that both teachers were former pupils of Virchow. Von Recklinghausen is very slow to publish his views, and very conservative as to the new themes in regard to micro-organisms and disease. He does not believe they play a principal role (Hauptrolle), and Von Recklinghausen has few equals in Germany as a pathologist.

About a month ago the celebration of the opening of the new Institute for Physiological Chemistry took place, Prof. Hoppe-Seyler reading an address before a distinguished audience, consisting of most of the professors, many eminent officials, &c. Among those from a distance was Baumann, now "ordinary" professor at Freiburg, and Hoppe-Seyler's most distinguished pupil. The professor's subject was: "The History of Physiological Chemistry and its relation to Medicine." He alluded to the injurious influence of the scepticism of the old Vienna school of the days of Skoda, Rokitansky, &c., when anatomy was regarded as the one, the only thing.

The new Institute is most perfect and most magnificent,—perhaps without an equal anywhere in the world. It seems like a fitting reward for the veteran investigator whose early work—indeed most of whose work—was done with the very limited resources and under discouragements that would have crushed any ordinary man. But genius cannot be crushed, and Hoppe-Seyler is an example of that truth. But, fortunately, medical men everywhere are now beginning to see that the future progress of medicine and physiology must largely be through chemistry. Yet what subject do medical students more slight than their chemistry, which is an *absolutely essential basis for the most modern physiology*, not to speak of its relations to pharmacology, clinical medicine, &c. ?

Schwalbe, formerly of Königsberg, has succeeded Waldeyer in the chair of Anatomy. He is a good teacher. On Saturday morning he gives a two-hour lecture on Embryology; but allows of an interval of five or ten minutes, during which the students can step out of their seats and relax the chain. It is doubtful if any class of men can successfully fix the attention for two successive hours on one subject, at least as dealt with in a lec-

ture. I was glad to observe that here embryology is dealt with by the department of Anatomy, to which it properly belongs; physiology is already overburdened, and in Strasburg chemical physiology is treated of in one course by Prof. Hoppe-Seyler all the semester through, and experimental physiology as a separate course by Prof. Goltz.

One morning Hoppe-Seyler casually mentioned in his lecture that there was to be seen in Strasburg an old ecclesiastical work dating long before Harvey's time, in which the circulation of the blood was described much more minutely than it had been by Harvey, and in such a way as to show a practical acquaintance with the facts.

Fillig, the renowned writer on organic chemistry, has a magnificent laboratory and lecture-room and a large number of students. He shows a powerful grasp of his subject, but as an accomplished lecturer he is, in my estimation, inferior to his distinguished pupil and former assistant, Prof. Rèmsen, of Johns-Hopkins University, Baltimore.

It is with regret I must record that of late the anti-vivisection mania has spread even to Germany, and that Goltz and Ludwig have been made the subjects of the most abominable caricatures. And it is singular that these two great teachers, with Burdon-Sanderson in England, who have been singled out for the attacks of these fanatics, are men of unusual kindness and goodness of nature. Goltz recently wrote an able defence of vivisection, "Wider die Humanaster." He is admirably fitted for such a task, which comparatively few men could judiciously undertake.

Of the clinical instruction at Strasburg I am not prepared to speak in great detail, my interests lying in other directions. Kussmaul, now an old man, holds a clinic every morning at 9 o'clock. A patient is brought into the theatre and some students selected to make the examination and diagnosis, he being thoroughly questioned by the venerable teacher. He is much revered by his pupils, as is also Von Recklinghausen. The surgical clinic is, I believe, conducted in a similar manner by Prof. Lücke.

I had almost forgotten to note that one of the most successful popularizers of science of the day in Germany, Oscar Schmidt, is professor of Zoology here. He has edited a number of English works of elementary science, such as Foster, Balfour, Roscoe, &c. In the popularization of science there is room for great improvements among the Germans.

The museum for Natural History is large and liberally stuffed with specimens, but all in admirable order. I should suppose it could be made to stock about three American museums of the same size. Entrance free and admirable regulation; the janitor is strictly forbidden to accept gratuities. The poorest can and do go to this museum every day in the week. I must not further trespass on your space, Mr. Editor, but trust that this rather rambling outline account of a famous university—one so far south that it is visited by comparatively few from America—may prove of some little interest to your readers. If it does not, then must I say, in the words of a well-known character, "They are not the men I took them for." T. W. M.

UNILATERAL HYPERIDROSIS AND TABES DORSALIS IN A FEMALE.

By T. D. REED, M.D., Montreal, Prof. Materia Medica, Mont. Col. Phar.

Mrs. L.,* aged 39, married seven years; has had one child, six years ago, which only lived a few days. In July, 1883, after a long walk, was surprised to find a copious perspiration on the right side of the face and head. Previous to this time she had a dry skin and did not sweat. She now finds that with active exercise, or with the warmth of the bed at night, or with nervous excitement as by fright, her hair on the right side of the head becomes wet, while beads of sweat appear on the face, throat and neck, limited to the right side. Simultaneously with the breaking out of the perspiration, the right cheek and ear become red and perceptibly hotter than the left. There is considerable injection of the conjunctiva at that time, and lachrymation is easily excited in the right eye at all times. The pupil

* This patient was shown at the meeting of the Medico-Chirurgical Society, Jan. 11th, 1884.

of the same eye is constantly dilated; both pupils respond but very slightly to the stimulus of light. There is some tenderness, on deep pressure, at the middle of the right sterno-mastoid muscle. Chronic inflammation of the right cervical sympathetic is presumed. If this nerve is at fault, the symptoms in the case indicate, that while the vaso-motor fibres are in a state of paralysis, the pupillary fibres are in a state of irritation.* The patient appears in good health, but is short.minded, and has at times a voracious appetite. Pulse feebly felt in both wrists, 85 standing. Urine very pale, free from glucose and albumen.

Tabetic Symptoms—Has had fulgurant pains in spots in the legs. When asked about her feet, said she had noticed them to be "asleep" sometimes, and had found her gait at times awkward, so that she has stumbled; once she fell on the sidewalk, cutting her lip. The toes seemed to droop. Knee jerk absent. Stands well with eyes closed. No ataxia of legs; no numbness noted. Syphilis cannot be positively excluded.

Has one sister living. Father and mother died at an advanced age. Nothing known of neurotic disease in the family history.

I am indebted to Dr. Buller for having made a careful examination of the eyes; he reports nothing diagnostic in the fundus. The right pupil measures 4½ mm. and the left 2½ mm. in the shade; accommodation good. Right lens has a few small pigment spots, suggestive of former slight iritis, and is a little turbid, indicating incipient cataract. Optic nerves slightly pale, but probably not exceeding physiological limits. Field of vision not impaired; color sense perfect.

The diagnosis of tabes dorsalis depends on the Argyll-Robertson pupils, fulgurant pains, and absence of knee-jerk. There is no evidence of neoplasm or aneurism in the neck or thorax to account for the hyperidrosis. The case is noticeable on account of the rarity of tabes in females in this country. No satisfactory reason has been given, as yet, for the great comparative exemption of the female sex. Neurologists of vast experience, such as Weir Mitchell of Philadelphia and Buzzard of London, refer only to three cases each.

* *Vide* Eulenburg and Guttmann on Sympathetic, trans. by Napier, fol. 58, for a similar case.

REPORT ON PHARMACOLOGY AND THERAPEUTICS.

By JAMES STEWART, M.D.,
Professor of Materia Medica and Therapeutics, McGill College.

BICHLORIDE OF METHYLENE.

Recently renewed attention has been drawn to this anæsthetic by M. Léon le Fort of Paris. It is over a dozen of years since its introduction as an anæsthetic into surgical practice. It has never been extensively employed, the reason of this being, that shortly after its introduction two or three deaths were attributed to its use. The preparation which is usually sold for bichloride of methylene resembles chloroform in its action upon the heart. It is a cardiac depressant, and, in over-doses, produces death by its paralyzing action on the heart. Considerable discussion has taken place as to the relative safety of chloroform and the bichloride of methylene. Spencer Wells has used the latter to induce anæsthesia in several hundred laparotomies, and without a death. He even did not notice a single dangerous symptom in any of the cases where it was administered. Others, however, have not been so fortunate in its use. Up to the present time there are 10 deaths recorded from it, and many cases have been reported where alarming symptoms made their appearance either during or after the inhalation of the substance, rendering necessary the most energetic treatment for the restoration of the patient. The great advantage that Spencer Wells claims for the bichloride of methylene in laparotomies is that it very seldom produces vomiting. It is owing to the great tendency of chloroform to produce vomiting that he has discarded it.

Methylene possesses the disadvantage that it cannot be used in hot weather on account of its low boiling point (87°). This is the reason why its vapor escapes so rapidly from the blood. Its effects are speedy, but not persistent. As a rule, there are no disagreeable sensations experienced from taking it.

B. W. Richardson, who introduced it into practice, said that the effects on himself were simply an impression that he had merely closed his eyes and opened them again. There is, at times, muscular disturbance preceding the state of complete anæsthesia, but this is not nearly so frequent as from the use of chloroform and ether.

Bichloride of methylene resembles bromide of ethyl in the quickness of its action and the rapidity with which a patient recovers from its anæsthetic effects.

Léon le Fort submitted several samples of the bichloride of methylene to the chemist, Regnauld, to test their purity. The latter found all that were obtained in Paris to be not what they were represented, but simply a mixture of chloroform and alcohol; while a sample obtained from Spencer Wells' purveyor proved to be a mixture of chloroform and methylic alcohol, in the proportions of 7 parts of chloroform to 1 part of methylic alcohol by weight. Le Fort has had considerable experience in this latter combination, made by adding the methylic alcohol to the chloroform, and not as it is usually manufactured. He says that the stage of excitement is of much less intensity and shorter in duration than from chloroform. In only one case was there vomiting, and then food had been given an hour previous to the administration of the anæsthetic.

Dr. Junker has administered this anæsthetic mixture of chloroform and methylic alcohol in 20 cases of laparotomies performed by Dr. Bantock in the Samaritan Hospital. The ages of the patients ranged between 23 and 69 years, and in all, the course of the anæsthesia was all that could be wished. The patients appeared as if in normal sleep, and awoke to full consciousness soon after stopping the administration of the anæsthetic mixture.

Judging from what has been published on the action of this anæsthetic mixture, or what commonly is known as English bichloride of methylene, it would appear to be a safer anæsthetic than chloroform, and in addition, to be almost free from the disagreeable effects which so often attend the administration of both chloroform and ether. It is a great point in favor of an anæsthetic that is to be used for abdominal operations, that it very seldom gives rise to vomiting. We know how frequently it follows both ether and chloroform, and if Regnauld's mixture proves to be nearly as safe as ether, then it will no doubt find extensive employment in abdominal surgery.

ON THE ADMINISTRATION OF SALICYLIC ACID.

The antipyretic effects of salicylic acid is one of the most

remarkable and important therapeutical discoveries of our age. Its antipyretic effects are, as is well known, best seen in acute rheumatism, but it is not alone in this disease that it reduces fever. The temperature of typhoid and other specific diseases is considerably influenced by it. In giving it internally, the points necessary to be borne in mind are the disturbing effects of very large doses and the rapidity with which it is eliminated. It should therefore be given in full doses at first, until its full physiological effects are brought about, and then continued in smaller doses, frequently repeated. It is best given in wafers or cachets. It should not be packed in capsules. About three doses of 20 grains each, at intervals of two hours, usually bring about decided symptoms of cinchonism (ringing in the ears, &c.) Ten grains every two hours, with intervals, gradually increasing to every three and four hours, will serve to keep up the effects. With the appearance of the symptoms of cinchonism, the temperature commences to fall, and, if the case is one of acute rheumatism, by continuing the acid in the smaller doses, frequently repeated, it is not apt to rise again. It is a curious and very important circumstance that full doses of salicylic acid or the salicylate of sodium do not interfere with the digestive functions of the stomach, and yet a very small quantity will prevent the action of pepsine.

A saturated solution of salicylic acid is a very good vehicle for the solution of alkaloids intended for hypodermic use. The acid dissolves in about 300 parts of water. If a drachm of it be added to a pint of water, and the mixture well shaken, a saturated solution, with some undissolved acid at the bottom of the bottle, will be the result. Then, if this be used entire, or diluted with an equal proportion of water, for making hypodermic injections, such a solution will remain free from growths of all kinds for an indefinite length of time, and will not be more irritant than when made from water alone.

THE ACTION OF COPAIBA ON THE URINE.

Quincke finds that the addition of hydrochloric acid to the urine of a patient who has taken copaiba causes it to become rose-colored or purple. This occurs immediately when the urine

is warmed, and at the border between the urine and the acid when they are poured in layers into a test tube. This coloring matter, or copaiba red, as the author terms it, gives three spectroscopic bands—a thin and indistinct one to the left of D, a brighter and a darker one in the green, and a broad indistinct one in the blue. When the urine is allowed to stand, the copaiba red becomes decomposed and the bands disappear. Nitric acid has a similar action to hydrochloric, and concentrated sulphuric acid also produces copaiba red rapidly, but destroys it again quickly. Quincke considers that the copaiba red is a strong acid. Possibly it is from this substance that a resinous body which appears in the urine is formed. The spectroscopic examination of copaiba red is interfered with by the turbidity which occurs on the addition of an acid; but the addition of alcohol cause this to disappear. When copaiba resin is administered instead of the balsam, the turbidity in the urine on the addition of acid appears more quickly than after the use of copaiba oil, but the red color never appears. It reduces copper on boiling very readily, but does not reduce bismuth. This effect occurs more readily with the resin than with the oil. Quincke thinks that the spectroscopic detection of copaiba in the urine may be useful as a means of diagnosing cases of doubtful glycosuria.

PARALDELYDE.

This—the latest addition to our hypnotic agents—promises to be useful and to fill a place not occupied by either opium or chioral. It is a colorless liquid at the ordinary temperature, although it, like glacial acetic acid, crystallizes if cooled below 50°F. It is obtained by treating aldelyde with dilute sulphuric or nitric acid. Its odor and taste somewhat resemble aldelyde, but it does not cause the same suffocating action when respired. It is soluble 1 in 10 of water. First introduced by the Italian physician Cervello as a hypnotic, it has now been used for a sufficient length of time to demonstrate that in some particular cases it is preferable to both opium and chloral.

Dujardin-Beaumetz has quite recently published the result of his investigations into the action of this drug, This included comparative observations with other known hypnotics and ano-

dynes. All the patients taking paraldelyde found it much less disagreeable than chloral. After administering an hypnotic dose of paraldelyde, the patient generally, in the course of 15 to 20 minutes, falls into a calm, refreshing sleep, which lasts from eight to twelve hours. Some subjects, especially females, experience a transient dizziness previous to falling asleep. No untoward effects follow its administration. No heaviness or headache is felt on awakening. It does not cause constipation. The perspiration after large doses exhales a strong odor of aldelyde. Dujardin-Beaumetz considers that as a pure hypnotic, paraldelyde is superior to even chloral and opium. It does not, however, possess any pain-stilling powers, so that if there is any pain present it will not act as an hypnotic. It is in the sleeplessness, unattended with pain, that its utility is seen. It has been found to act very well in the insomnia of the morphia-maniac, and in cases of simple wakefulness unattended with pain.

The dose is 15 minims to one drachm, given in syrup.

THE DANGER OF LARGE DOSES OF QUININE.

Is the use of quinine in large doses ever dangerous in hyperpyrexia, with tendency to heart failure? Especially in cases of typhoid fever, it has often been contended that large doses of quinine are responsible for sudden deaths when this agent has been given.

The physiological action of quinine on the circulatory system in small doses (from 2 to 5 grains) is that of a tonic. It stimulates the heart, both in frequency and force. It has, however, been suspected for some time that, in large doses (from 20 to 60 grains), it has a directly opposite action—that it acts as a cardiac depressant. From recent experiments performed by Laborde, this supposition appears to be well grounded. These experiments seem to prove that there is a connection between the sudden deaths in typhoid and other low forms of fever and large doses of quinine. The effect may be brought about in a double manner, either by a direct depressant action on the heart from a single large dose, or to the cumulative effects of many doses bringing about a diastolic arrest. When the excretory powers of the kidneys are diminished, then the quinine is retained in the blood and acts deleteriously on the heart.

There arrives a time in diseases like severe typhoid and pneumonia where heart failure is apt to set in, and where, in consequence, large doses of quinine will prove dangerous. This, in the case of a severe pneumonia, occurs about the fifth or sixth day, and during the second week in typhoid. The temperature, after heart failure begins, may be as high or even higher than before. This is an important fact, in view of the almost routine practice of prescribing large doses of quinine in high temperature, whatever the condition of the heart may be. Large doses of quinine begin to show their antipyretic effects in from one to two hours after their administration; they reach their maximum effects in from 6 to 8 hours, and the effects remain for 24 or 36 hours. These facts should be borne in mind when we decide to administer agents to counteract the depressant effects of quinine on the heart. In giving ammonia, for instance, for this purpose, it would be useless to give a single dose of it; but it should be administered at short intervals for at least 36 hours to counteract the effects of a single large dose. Dr. A. A. Smith of New York says that he has found small doses of opium to be the best antagonist to the depressant action of quinine on the heart. In doses of from a quarter to half a grain, opium is a cardiac stimulant, besides being, under conditions of high temperature, a great sedative to the nerve perturbation which accompanies such a condition.

THE USES AND MODES OF ADMINISTRATION OF DESICCATED BLOOD.

Desiccated blood is indicated in all cases where it is desirable to give iron. It is not only a hæmatinic, but also a nutritive agent of high value. When well prepared, it is odorless, and can be taken quite readily. It may be administered either by the mouth or by the rectum, preferably, however, by the former method. Dr. Stewart, the introducer of it into practice, recommends it to be given with glycerine and brandy, or simply in solution in water. He recommends the following formula:—

℞ Desiccated Blood, - - ʒ vi.
Aq., - - - - - - - ʒ iii.
Dissolve and add: Brandy, Glycerine, āā - - ʒ i.

Sig—A tablespoonful three times a day.

In cases of fever, it is not well to give over a teaspoonful at a time to commence with, and as the stomach will bear it the dose can be increased. When preparing an aqueous solution, it is recommended to pour the scales into the water and not the water into the scales. Of course, cold water should be used, as hot water will coagulate it.

A FATAL CASE OF ETHER INHALATION.

Mr. T. Holmes records in the *British Medical Journal* for March 15th a death from the administration of ether. The patient was a married woman, aged 43. She was sent up from the country on account of a fibrous tumor of considerable size growing from the uterus into the vaginal cavity. After remaining in the hospital for a few days, it was decided to remove the tumor on account of the patient becoming weak from the loss of blood. In all other respects she appeared to be healthy, with the exception of a goitre of considerable size. While taking the ether, a sort of whistling sound was observed in the breathing, which ceased on the chin being raised. When she had beeome insensible (but before the corneal reflex had ceased), the couch was wheeled into the operating theatre, and as she was being raised on the operating table, it was noticed that her breathing had ceased, and that the face was very livid; the pulse was beating regularly. The tongue was at once pulled forwards, and as this did not restore the breathing, artificial respiration was at once commenced, but as this produced no result, the trachea was rapidly opened and a large tube introduced, the artificial respiration being still persevered in. This seemed for an instant to promise success; her face became a little less livid. The attempt at respiration soon failed. A catheter was now passed down the trachea, and attempts made to inflate the lungs—at first with the mouth, then with a bellows—but all in vain. For a long time the pulse could be felt in the femoral artery, full and regular at first, then less distinctly, till it ceased, and it became clear at length that all attempts at resuscitation were fruitless.

At the post-mortem examination, nothing was found to explain the cause of death; the lungs, heart and kidneys were normal. The goitre, according to Mr. Holmes, had no part in the fatal

issue. The case appears to be one of direct paralysis of the respiratory centre in the medulla, brought about by the depressant action of the ether.

No mention is made of the purity of the sample of the anæsthetic employed, except that it had been used on three previous occasions without giving rise to any untoward symptoms. Judging from the recorded cases of deaths from ether inhalation, it would appear that this deplorable accident is much more common in England than it is on this side of the Atlantic. Whether this is owing to their using a less pure ether in England or not, it would be hard to say.

Reviews and Notices of Books.

A Treatise on Pharmacy: Designed as a text-book for the Student, and as a guide for the Physician and Pharmacist, containing the officinal and many unofficinal formulas, and numerous examples of extemporaneous Prescriptions.—By EDWARD PARRISH, late Professor of the Theory and Practice of Pharmacy in the Philadelphia College of Pharmacy. Fifth edition, enlarged and thoroughly revised. By THOMAS WIEGAND, Graduate of the Philadelphia College of Pharmacy. With 256 illustrations. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Brothers.

The last edition of Parrish's great work has been thoroughly revised, and brought in accord with the new U.S. Pharmacopœia. The work justly ranks next to the U.S. Dispensatory in the completeness and thoroughness with which it deals with the subject. The subject is discussed under the following heads: Part I—Furniture and Implements. Part II—On Pharmacopœias, Weights and Measures, Temperature, Generation and Heat, and Heat as applied to Pharmaceutical purposes. Part III—Pharmaceutical Process and Apparatus. Part IV—Inorganic and Pharmaceutical Chemistry. Part V—Pharmacy in its relation to Organic Chemistry. Part VI—Galenical Pharmacy. Part VII—Extemporaneous Pharmacy; Appendix. Part VIII

treats at length the subject of prescriptions, the language to be used in them, and the best method of writing them; the art of selecting and combining medicines; medicine suited to the liquid form; chemical and pharmaceutical incompatibles, extemporaneous solutions, &c. The appendix is devoted to directions for the management of the sick chamber and diet for the sick.

To the physician in the country, or to anyone who dispenses his own drugs, this is a work of great value. Next to thoroughly understanding the actions of a drug stands the knowledge of how to administer it in the most approved form, and we know of no work in the English language that is more likely to aid a man in acquiring this knowledge than the work under consideration. No pharmacist who aims at being abreast of the times can afford to be without it.

A Manual of Practical Hygiene.—By EDMUND A. PARKES, M.D., F.R.S., late Professor of Military Hygiene in the Army Medical School, &c. Edited by F. S. B. FRANÇOIS DE CHAUMONT, M.D., F.R.S., F.R.C.S., &c. Sixth edition, with an appendix giving the American matters relating to Hygiene, prepared by and under the supervision of FREDERICK N. OWEN, Civil and Sanitary Engineer. Vols. I. and II. New York: Wm. Wood & Co.

This important and valuable standard work of Prof. Parkes has now been incorporated into the "Library of Standard Authors." It contains the full text of the most recent English edition, together with all the woodcuts. The additional remarks which are interpolated by the American editor considerably increase its usefulness in this country. In its present form it certainly makes one of the most extensive and most reliable works of reference to be had.

Surgical Applied Anatomy.—By FREDERICK TREVES, F.R.C.S., Assist. Surgeon to the London Hospital. Illustrated with 61 engraving. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Brothers.

This is one of the series of manuals for students, and is mainly

intended for the use of those preparing for their final examination in surgery. The practitioner, however, will find much in it that will prove of benefit to him in his daily practice. There is a short description (excellent as far as it goes) of the cutaneous distribution of the nerves. This is a portion of anatomy, although of great practical importance, which, until quite recently, has been much neglected. Fortunately for the practitioners of the future, the majority of the anatomists of the present day are alive to the vast importance of applied and scientific anatomy.

Books and Pamphlets Received.

THE MEDICAL DIRECTORY OF PHILADELPHIA FOR 1884. Edited by Samuel B. Hoppin, M.D. Philadelphia: P. Blakiston, Son & Co.

TRANSACTIONS OF THE AMERICAN OPHTHALMOLOGICAL SOCIETY. Nineteenth Annual Meeting, 1883. Published by the Society.

ILLUSTRATIONS OF THE INFLUENCE OF THE MIND UPON THE BODY IN HEALTH AND DISEASE: Designed to elucidate the action of the imagination. By Daniel Hack Tuke, M.D., F.R.C.P., LL.D. Second American, from the second English, edition. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Brothers.

A STUDY OF THE BLADDER DURING PARTURITION. By J. Halliday Croom, M.D. Edinburgh: David Douglas.

ON THE PATHOLOGY AND TREATMENT OF GONORRHŒA. By J. L. Milton. Fifth edition. New York: Wm. Wood & Co.

LEGAL MEDICINE. By Charles Meymott Tidy. Vol. III. New York: Wm. Wood & Co.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, Feb. 15th, 1884.

T. A. RODGER, M.D., PRESIDENT, IN THE CHAIR.

DR. OSLER exhibited the following pathological specimens:—

1. *Portions of Muscle, Intestine and Kidney from a Horse dying of Toxic Hæmoglobinuria or Azoturia.*—Dr. Osler mentioned that this disease was rather common here, and that usually the animals recovered. The disease generally attacks well-fed, well-cared horses which have been kept in the stable for a few days and then put to work again. The horse, while in the stable and on taking him out, appears perfectly well, but after an hour

or two's work becomes weak, trembles and falls, and may die in 24 hours. The muscle shown was from the gluteal region, which is the part most affected. It had a parboiled appearance, was pale, and much infiltrated with serum. The intestines were deeply congested. The kidneys were somewhat swollen, soft, and congested. On section, the Malpighian tufts and cortical portion were seen to be engorged. Microscopically, the muscles had a teased appearance, with the striæ almost obliterated. The kidneys showed the Malpighian tufts to be congested. The epithelial cells of the tubules were filled with granular matter. The urine drawn by catheter was coffee-colored, and contained albumen and large granular tube casts. This disease is thought by Williams and Fleming to be caused by an excess of nitrogenous matters in the blood, though the pathology is not at all clear.

DR. ROSS said it was very remarkable to see such advanced tissue changes produced in so short a time, and asked Dr. Osler if the disease might not have been latent, and suddenly, from some outside cause, develop somewhat in the same way as does acute inflammatory nephritis in a child recovering from scarlet fever. The child, though appearing well, is really not so, for a slight cold may suddenly light up the latent kidney trouble.

DR. OSLER thought that possibly Dr. Ross' theory might help to clear up some of the difficulties

2. *Organized Thrombus of Left Iliac Vein.*—This specimen was solid and firm, with absence of coloring matter of the blood. Dr. Osler remarked how variable was the time taken to organize a thrombus. Here it took only three days to be as far advanced as in other cases of ten or even fourteen days' duration.

3. *Dermoid Cyst of Ovary containing sebum, hair and teeth.*—This specimen, about the size of two closed fists, was removed by Dr. Fenwick, and contained five teeth, one of which, attached to a piece of bone, was a well-formed incisor.

4. *Rapidly-formed Scirrhus of the Liver, with Tumor at side of the neck.*—The above was removed post-mortem from a man sent to the hospital from Ottawa. He came to have the tumor in the neck removed. On admission, no abdominal trouble

was noticed or suspected. The tumor in the neck was situated in the upper triangle, moveable, and had been growing six or eight months. It felt as if it could easily and safely be removed, but symptoms of difficulty in swallowing and alteration of voice pointed to implication of the pneumogastric nerve, so that the case was watched for a few days, when it was observed that the liver was enlarged. The man said he had been growing larger for about three weeks. He had been a hard drinker. From the rapidity of growth and absence of jaundice, Dr. Shepherd diagnosed cancer, and had him transferred to the medical side, under Dr. Ross. On dissecting out the neck tumor, which was about the size of one's fist, Dr. Shepherd found it attached to the deep blood-vessels and nerves, the pneumogastric being deeply involved, and some of its strands separated. The liver weighed nearly nine pounds; on its under surface was a huge, isolated mass, with secondary nodules around.

Dr. Osler said that both tumors were scirrhus, and that it was hard to say which was the primary.

Dr. Shepherd thought the one in the neck must be, from the fact that it had been growing so much longer.

Dr. Ross said that this growth in the liver was the fastest he had ever seen; every forty-eight hours would show a noticeable increase in size. The man never had pain till ten or twelve days before his death, when he had some inflammation of the peritoneum.

Sarcomatous Tumor removed from the Thigh.—Dr. Perrigo exhibited the above, which he had removed from a lady aged 38, the mother of six children. It was attached to the periosteum, below and a little behind the great trochanter, extending under the gluteus maximus, and completely filling the hollow between the trochanter and tuber ischii. It did not involve the muscles, but simply displaced them. It rested upon the sciatic nerve. The patient first consulted Dr. Perrigo, about two years ago, for sciatica, and about one year ago he detected a tumor about the size of an egg, and freely moveable. It increased in size steadily, and during the past three months very rapidly. Four or five years ago this lady had had an attack of phlegmasia dolens,

from which she made a tardy recovery. The tumor was about six inches long by four thick. A recurrence is looked for.

Puerperal Fever.—DR. ALLOWAY read a paper* on this subject, in which he strongly advocated the use of suppositories containing 10 grains each of iodoform and boracic acid, made by pressure, with cocoa butter. As a prophylactic vaginal antiseptic injection for normal labors, he recommends a solution of Hydrarg. Bichlor., $\frac{1}{5000}$ strength. He laid stress on the fact that the syringe used must be a new one.

DR. KENNEDY said he had seen a very large number of cases of puerperal fever; he had had three outbreaks of the disease in the lying-in department of the Western Hospital, and a great many in the practice of his *confrères*. In the hospital, he had noticed how easy it was for the disease to originate, and was struck with differences in the temperatures according to the nurse on duty. With some nurses the temperature ran high, but with others very little change would be observed, and he believed that strict antiseptic precautions were more necessary with obstetric cases than in surgical operations. In the first outbreak in hospital, it spread from a private patient attended by a physician who at the time was in close attendance on a case of puerperal fever outside. He stated that most of the modern authorities on obstetrics grouped under the heading of puerperal fever all the different conditions which might arise during the puerperal state; but, personally, he did not think it proper to look upon a pelvic cellulitis, inflammation of the uterus, or a phlegmasia dolens, as more than being coincident with the fever, although it was thought by some that these conditions were alternatives of the disorder. Some years ago a paper was published in an English periodical giving three forms of the affection. First, the pyæmic; next, auto-infection; and, thirdly, by contagion. He believed that this division was the best, and agreed fully with his own observation. The pyæmic form was rare, and that by contagion also less frequent than by auto-infection,—the latter form comprising by far the greater number of cases he had

* See March (1884) number of this journal, page 156.

seen. As for the general treatment of these cases, it must be chiefly preventive, and he had found good results from Dr. Goodell's plan of placing the patient upon quinine in combination with an acid, and adding either morphia, ergot or digitalis, as may be indicated. During the presence of the fever, he had found turpentine in 10-drop doses every four hours to be of great value. For the local treatment, every case would require to be treated according to the coexisting complication. As for iodoform, this had been used in the Western Hospital for over three years, being introduced into the uterus whenever the discharge from that organ was offensive; and as the majority of cases in hospital were primipara, vaginal lacerations were frequent, and in these it was the constant practice to introduce iodoform suppositories after each injection. For the injection, he at first used carbolic acid, but although this was more cleanly, the permanganate of potash, was now preferred on account of its more powerful action in purifying the discharges and in destroying septic germs. Of the induction of puerperal fever by zymotic disease, he would mention a case which occurred in hospital. A yonng girl, who had been an inmate for some time awaiting her expected confinement, was allowed to visit her friends, at whose home there were sick children. A fortnight afterwards she was taken with labor pains and delivered naturally. At the time her temperature was noticed to be 103°F. As puerperal fever was suspected, she was isolated. The following day the bright rash of scarlet fever covered her entire body, and the nature of the disease thereby indicated. Death ensued; and in this case there could be no doubt of its cause, which could not be true puerperal fever, as it manifested the high febrile state before the labor, which latter was somewhat premature and a consequence. In connection with this subject, he would draw attention to that condition which was known as milk fever, the weed or ephemeral fever. Very little mention was made of this disturbance by the later obstetric authorities, but a separate chapter would be found in Churchill. As he had known some of his younger *confrères* to mistake it for puerperal fever, he thought more attention should be directed to it. Formerly it was more

common, and its rarity now must be ascribed to the better diet prescribed, and also to the child being suckled soon after birth, not waiting until the breasts became gorged with milk, as was the old practice. In hospital, the few cases which had occurred were in badly fed women, and had given an opportunity to students to diagnose between the two conditions. These cases were always marked by the violence of the chills, which commenced between the shoulders. In septic forms, the chill spread from the extremities. This difference was strongly diagnostic; and as ephemeral fever ran its course in from 24 to 48 hours, marked by profuse sweating and high temperature, it was often treated by a placebo so as to allow the case to run its course for illustration. Generally Aconite and Ammon. Acet. was given. He had no doubt that such cases were often mistaken for puerperal fever, and treated by large doses of quinine, the subsequent rapid termination of the case being ascribed to the influence of the quinine. In puerperal fever, he had no faith in the large doses of quinine usually given, not having seen any beneficial results from their use.

DR. TRENHOLME said his experience with puerperal fever was limited to consultations with others, having never had a case in his own practice. He believed each case ought to be treated, not by any rule, but separately. He also spoke against the common method of twisting the placenta for removal of the membranes, believing that it often breaks inside, enclosing a small clot of blood, which would do mischief by decomposing. He advocated Dr. Goodell's rule of getting the patient to walk from the bed on which she had been confined to her own room, and also of allowing her to sit up each day for a short time to favor drainage.

DR. GARDNER remarked that while he admitted the great value of intra-uterine antiseptic injections, and of intra-uterine use of iodoform in the manner recommended by the reader of the paper, it could only be useful in forms of puerperal poisoning by absorption of septic stuff from the decomposition of matters contained in the uterus—the sapræmia of Matthews Duncan; the ichor-apræmia of others. He believed with Dr. Robert

Barnes* in the existence of another form of puerperal blood-poisoning, with fever, due to failure of the lymphatic system and liver to modify the waste stuff thrown into the circulation from the disintegrating uterus and appendages, and to failure of the excretory organs—the lungs, kidneys and skin—to remove from the system that same waste-stuff. In such a form of fever, he could not see how such remedies could have any effect. Their utility must always be limited. With reference to the mode of intra-uterine injection, he had had recently a case of enucleation of a large sloughing sessile myoma, in which the after-treatment consisted in retaining within the uterus for a fortnight a double drainage-tube, through which irrigation, at times continuously, and again intermittently, was practised, which suggested to him that this might, in some puerperal cases, be the best method of securing drainage and of irrigation of the cavity of the uterus. The conditions, it is true, are not exactly similar. In both there is a raw surface on the interior of the uterus, but in one there is superadded the importantly complicating blood conditions from the presence of waste-stuff from the disintegrating uterus. In the case of the myoma alluded to, the antipyretic effect of the irrigations was most marked several times in the course of the after-treatment.

Dr. Kennedy mentioned having recently to treat an unusual accident, viz., dislocation of the head of the humerus, with fracture of the coracoid process of the scapula.

Dr. Shepherd made a few remarks on the difficulty of diagnosing such cases.

Extracts from British and Foreign Journals.

Unless otherwise stated the translations are made specially for this Journal.

Acute Rheumatism.—The following appeared in the *Jour. Am. Med. Ass'n.*, Dec. 22, 1883:—Under this head the December number of the "Proceedings of the Medical Society of the County of Kings" has four distinct articles. Dr. Benj. Edson describes a case of the acute form treated by

* *Amer. Jour. Obstet.*, vol. xv., page 53.

sodium salicylate grs. x. every three hours, and relieved in two weeks' time. It returned in a sub-acute form and proved very obstinate, not being removed by the sodium salicylate. Chorea developed, and the symptoms were finally subdued by—℞ Ext. cimicifugæ fl. ʒ ss, potass. iodidi grs. v, four times a day.

Dr. H. A. Fairbairn reviews the results of treatment of acute rheumatism, taking from the English journals the reports of between four and five hundred cases treated by salicin and salicylate of sodium, all being recorded hospital cases. The conclusions drawn are that they (these drugs) make comfortable an otherwise painful and distressing ordeal; that the duration of the disease, as a rule, is not shortened by it, and the heart not protected; that it fails entirely in some cases. The dose varied from ʒiss to ʒij in divided doses (of sodium salicylate) during the twenty-four hours. By some ℈j doses were given every two hours or hourly, until relief was afforded. Accidents having occurred during its administration, and sudden death having followed, the recognition of the presence of a powerful drug, and the consequent care necessary in its use, would seem to make this last dose a hazardous one. Dr. Maclagan prefers salicin in ℈i to ℈ij doses hourly for six hours, then every two hours. In two cases given, improvement was marked in twenty-four hours and the patients convalescent in four days. Salicin is preferred, as not producing depression, and therefore not prolonging convalescence. The drug must be given in large doses, so as to thoroughly saturate the system. The use of methyl salicylic acid, or oil of wintergreen, is reported in ten cases at St. Luke's Hospital, New York, as employed with good results in ♏x to ♏xv every two hours. Here Dr. Fairbairn makes a point of dwelling on the importance of looking to the activity of the eliminating organs when using such powerful drugs. The blister treatment, applied over the heart and about the joints, has sixty-four cases recorded to its credit as cutting short the fever, relieving pain and having no heart complications. Dr. Fairbairn found relief given by large doses of the tincture of the chloride of iron, in weak and anæmic cases, where neither the alkaline nor salicylate treatment ap-

peared to do good. Dr. Craig, of Jersey City, reports benefit in forty-eight hours, and a cure in five to six days, from the use of the syrup of hydriodic acid in 3ij doses every two or three hours until relief, then 3j three times daily. Dr. Flint, of New York, allowed a number of cases of acute rheumatism to pursue their course without any treatment. They all recovered, the mean duration of the disease being a little under twenty-six days. Our most approved method of treatment gives about the same average.

Dr. J. E. Richardson writes enthusiastically in favor of the treatment of acute rheumatism by the salicyl compounds, giving a brief analysis of thirty cases so treated. He used the salicylate of sodium, eighty grains to the twenty-four hours. In several cases there was a decided cumulative effect; in but one, however, was this effect toxic. Local treatment by cotton wool and hot fomentations and the use of opiates was not neglected. There was no hyperpyrexia in these cases, and in nearly fifty per cent. the temperature did not exceed 102° F. Subsidence of pyrexia occurred, on the average, in 3.1 days. In fifteen cases it had become normal at the end of forty-eight hours. The average duration of joint pain was 4.5 days. The average time in which patients were kept under observation was 10.1 days, this being the time they were able to resume their employment. Heart complications occurred in one case; this was a case of endocarditis. He believe the salicyl treatment *lessens* the tendency to heart disease, probably through the reduction of temperature and the destruction of the rheumatic poison. Relapses took place in five cases while the patients were still under tolerably full doses of the drug. Dr. Richardson draws the following conclusions:—1. The more acute the case the more marked the relief afforded by the salicyl compounds. 2. If beneficial effects are to result from the use of the drug, they should be observed within forty-eight hours. 3. If the remedy is administered early in the disease, and in not too large doses, the tendency to heart disease is greatly diminished. Dr. W. B. Chase, in considering the "Prophylaxis of Rheumatism," recognises first the direct transmission of the rheumatic diathesis;

then its prevalence in the temperate zone and under the meteorological conditions of humidity with a low temperature. Consequently, his prophylaxis is introduced by directions of how to avoid exposure and the wearing of proper clothing, such as silks and woollens, next to the skin. A proper care of the emunctories, as bathing for the skin to keep the perspiratory glands in good working order, and attention to the urinary secretion is dwelt upon. Alcoholic drinks are assumed to be a prolific cause of rheumatism, but in what way is not clearly defined. The undue formation of lactic acid in acute rheumatism is recognised as the cause of the hyperacidity of the secretions, and Bartholow's three types are given, viz. :—1. Active, sthenic cases in persons of robust health, youth or early adult life. Treatment: Salicin and its compounds. 2. Asthenic cases in the anæmic and debilitated, often the young. Treatment: Tr. ferri chloridi. 3. Obese persons and beer-drinkers, with flabby muscles and acid indigestion. Treatment: Alkalies. Probably most persons of rheumatic antecedents will derive benefit, and thereby reduce the liabilities to its constitutional development, by more or less frequent use of natural alkaline and sulpho-alkaline waters.

The Treatment of Epilepsy.—By Dr. William Pepper.—This teacher, in the *Medical and Surgical Reporter* for January 12, 1884, says:—In a hospital we see the most unfavorable cases of this disease, for the sufferers rarely come to us until they have had a variety of treatment outside and until the physical and mental condition has become seriously impaired by the disease. Although an institution of this character is one of the worst places for the study of the therapeutics of epilepsy, there is no better place for the study of the symptomatology, pathology and diagnosis of the disease. I want you in the very beginning of our consideration of these cases to disabuse your minds of the idea that epilepsy is an incurable affection. In many cases it is incurable, yet there are many cases which are very amenable to treatment.

In the majority of cases the disease shows itself in some during childhood, or, if the disease itself does not appear, the

child will show a tendency to it. For instance, the child will have one or two convulsions when teething or at the beginning of an attack of measles or scarlet fever; and after teething is over or these attacks of acute disease have passed away, the child will have no spontaneous convulsions for a number of years, and the parents will have entirely forgotten the circumstance, until the age of seven, eight or nine arriving the child, without apparent cause, will again have a convulsion, and from that time be a confirmed epileptic. Such is very commonly the history. Still more usual is it for the occurence of some accident to arouse this tendency to convulsion—for instance, a child will have a fall, striking its head, and after that convulsions will be developed. In another class the tendency is so great that the convulsions occur from the most trivial causes, as fatigue, excitement, indiscretion in diet or other form of reflex irritation.

Among the predisposing causes inheritance is a powerful one. When a child comes of a family of strongly marked nervous temperament, and if the child began at an early age to show a tendency to irregular nervous manifestations, the probability is that there is such a profound morbid tendency of the nervous system that no effort will control or eradicate it. Another predisposing cause is long-continued exhausting illness. This may excite a tendency to convulsions at any age. Where there has been no inherited tendency, and where the child has not shown a disposition to convulsions, these attacks after protracted disease are not of so unfavorable omen as where they come on in consequence of a constitutional tendency.

I need not say to you that accidents in children often produce this tendency. Children so frequently meet with accidents, that it is exceedingly difficult to say whether the convulsions have resulted from a blow or whether the child has an inherited tendency which is just showing itself. Still you will be pressed for an opinion by the parents. If the accident was followed by unconsciousness and paralysis or mental affection you will have no hesitation in expressing the opinion that some injury has been done, and according to the seriousness of the injury and its curable character will be your prognosis. More frequently,

however, you will be forced to conclude that the shock to the nervous system has excited the convulsions. If the injury has been slight, the prognosis is bad; but if the injury has been severe, the prognosis is more favorable. If there is evidence of permanent injury to the brain, the prognosis is of course unfavorable.

In children with convulsions, where there is a history of an injury with perhaps some lesion of the head, you will often find it difficult to decide whether or not any operative interference should be adopted. Usually you will find that you cannot decide upon having the head trephined. Yet I am satisfied that we ought to trephine the head for epilepsy more frequently than we do. Wherever there is a lesion of the cranial walls, although there may be no depressed fracture where there is possibly some lesion of the membranes and where the convulsions cannot be controlled, my judgment would be strongly in favor of trephining. I have seen some excellent results follow this treatment.

Another and extremely difficult question comes up in the treatment of young children, and that is the question of intellectual development and training. A child of five or six is attacked with epilepsy. Such children are often among the brightest and most intelligent, and frequently are even precocious in their intellectual development. Yet it is clear that if the brain becomes excited by study, too much reading, or violent play, the convulsions will become more severe and frequent. To decide how far we should interfere with intellectual work, and how far the advantages of such interference counterbalances its disadvantages, is one of the most difficult problems to solve. My own judgment is decidedly against allowing these children to study or go to school. If taught, they should be taught at home, and emulation, ambition and excitement of every kind should be studiously avoided. Specious as are the arguments pressed upon you by the parents against this plan, the results of yielding are usually bad.

Epilepsy, even when taken at the earliest period, is not a disease which in my experience has been cured by drugs alone.

When I have succeeded in eradicating this tendency, and the cases are rare in which success has been attained, it has not been by drugs alone. It has been by the regulation of diet, regimen and hygiene, and secondarily by drugs. But allowing the child to go to school, and when the convulsions become more frequent increasing the dose of bromide of potassium, and when that loses its effect changing to bromide of calcium, bromide of lithium or hydro-bromic acid, can have only one ending, and that is the enfeeblement of the whole nature of the patient, mental, moral and physical, and the settling upon him of a hopeless bromide habit without eradicating the epilepsy. There are some few cases in which a radical cure can be effected by drugs. There is a large number of cases where, with proper hygiene and the continued use of suitable remedies, the disease can be kept in check indefinitely. There is still a larger number of cases, and this may be said of almost all cases, in which if you depend upon drugs alone, and do not pay the first and closest attention to the regulation of every point of the daily life, you will find that the case goes from bad to worse, and that the effects of the drug have been bad, without influencing the disease. There is an enormous amount of damage done by the way in which bromides are used in convulsive affections.

The child requires a certain amount of training, and should be encouraged to use its mind in certain ways, for this exerts a beneficial and tonic influence. As I have said, the stimulus of competition, as in schools, is always an injury. These children, therefore, require a totally different arrangement of their daily life from that of healthy children. It should be based upon the fact that they are suffering from nervous prostration as well as nervous irritation. In speaking thus I do not allude to those cases in which some source of reflex irritation has been allowed to continue and keep up the convulsions. Such a child seems to me to be suffering from nervous prostration in a very real sense, and I think that the best results will be obtained by treating the child for that condition.

I should regulate the life of such a child in the following way:—Go to bed at seven o'clock, and lie in bed until eleven

o'clock in the morning; take a walk, come in and study, dine; after dinner, play or walk again, then rest and retire at the hour mentioned. Sometimes this can be carried out; at other times the child is so restless that any attempt to enforce such rules will do more harm than good. Where the child can be restrained, I regard prolonged rest in bed as one of the most useful adjuncts to the treatment of juvenile epilepsy. I have seen remarkable results follow this line of treatment.

I shall allude to only one more point to-day, and it is one about which much has been said of late—that is the question of genital irritation, as provoking attacks of epilepsy. I think that too much attention and importance has been given to this point. I think that you will be doomed to disappointment if you expect to have a great deal of good follow the circumcision of adherent and contracted prepuces, which is the most common expression of genital irritation. In the female, there are a few local causes of irritation of the genitals. I know that there are cases in which an inherent prepuce with irritation of the mucous membrane has excited the convulsion, and after the removal of this cause no other convulsions have appeared. Far more commonly, it will be found that children who, with an adherent prepuce, get convulsions, are epileptics in whom that may be one of the exciting causes, and although this may be removed it will leave behind the epileptic tendency, and convulsions will occur from some other cause. In some cases after the operation of circumcision complete relief has followed, but in a larger number of cases the condition of the prepuce has been found to be only one of the elements of irritation.

The same thing is true of worms in the intestinal canal. This is a rare cause, and still more rarely is it the only cause of irritation. We should, of course, carefully search for these causes of external irritation and remove them, and above all, as far more important, should we see to it that there shall be no condition of intestinal irritation.

Antiseptic Obstetrical Methods.—By Dr. W. W. Jaggard, of Chicago, Ill.—In the *Medical News* of January 26, 1884, this writer says:—Prof. Carl Braun prac-

tised antiseptic methods in obstetrics with critical exactness in the Vienna Lying-in Hospital before the discoveries of Weber, Billroth, Pasteur, Schwann, Koch and Lister were made known. It is the object of this paper to sketch briefly one of his contributions—Vienna Antiseptic Obstetrical Methods.

I. *Hospital Ventilation.*—Ten wards of the so-called new wing of the Vienna General Hospital have been used, *without interruption*, from 1834 to the present time, for the practical iastruction of physicians in obstetrics. The paramount importance of perfect ventilation received immediate recognition upon Braun's accession to the control of the hospital.

Braun says upon the subject of hospital ventilation (*Gynäkologie* p. 884):—"I have arrived through practical observation at the recognition of the fact, that the rapid and effective prevention of putrefaction by means of generous and adequate ventilation, is to be regarded as a good prophylactic rule against puerperal fever; that not the greater number of puerperal women who are annually cared for in a hospital, and not the greater number of puerperal women in one room, but the insufficient change of air in a cell for one individual in the smallest hospital, is to be regarded as the important factor in the spread of puerperal fever; that puerperal women, therefore, in order to be effectually guarded against puerperal fever must be isolated, not by insulated houses and gardens, not by stone walls, but by the continuous conveyance of large quantities of fresh, pure, warm air by means of a cheap, practicable, easily executed method."

II. *Treatment during last weeks of Pregnancy.*—During the period prior to confinement (a space of four or six weeks) the pregnant woman is compelled to take baths at regular intervals, and her axillary temperature is carefully noted. Her last act before entering the lying-in chamber is to take a warm bath, in which soap is vigorously employed.

Treatment during Parturition.—Upon entering into the lying-in chamber in the first stage of labor, if her temperature is pathological, she is transferred at once to another ward. Vaginal examination is permitted an individual upon the conditions:

(1) That for the space of twenty-four hours preceding he has not been within the sphere of contagion of any zymotic disease, and that his hands have not come in contact with any wound or cadaver; (2) that his hands are absolutely clean.

After a vigorous application of soap and nail-brush in a two and a half per cent. solution of carbolic acid, the hands are rendered thoroughly antiseptic. Before making the examination it is customary to dip the exploring finger into a solution of hydrochloric acid in glycerine.

During parturition it is usual to douche from time to time the external genitals with some antiseptic fluid. In every case of protracted labor, after rupture of the bag of membranes, sitz baths at regular intervals are enjoined.

When operative procedure is indicated, the vulva and vagina are thoroughly irrigated with a two per cent. solution of carbolic acid before the introduction of any instrument. Extreme attention is paid to the exclusion of air from the uterine cavity during the process of irrigation. After the completion of the irrigation, a *bacillus*, containing five grammes of iodoform, is introduced within the uterine cavity, and an equal quantity is usually placed within the vagina.

Perineal ruptures and episiotomy wounds are carefully cleansed and immediately united by *serres fines* or sutures. Contused and lacerated wounds of the vagina are painted over with neutralized tincture of sesquichloride of iron, acetic clay, tincture of iodine, Goulard's extract, thymol, or carbolic oil. All wound surfaces are finally dusted over with iodoform powder.

The axillary temperature of each patient is taken and recorded at intervals of three hours during the entire period of parturition. If the temperature becomes abnormally high, the patient is at once isolated.

In a recent lecture upon this subject Braun said:—"I am perfectly convinced that every parturient woman in a febrile condition on account of endometritis, with or without *tympanites uteri*, possesses the capability of infecting, during her stay in the room; whether the transport of the pernicious influence is effected by the examining finger or by the polluted air pene-

trating the vagina, I should like to leave undecided. I, myself, hold that the one as well as the other mode of transport is possible."

IV. *Treatment during the Puerperium.*—Immediately after labor the soiled linen is removed, and the patient enveloped in linen sheets heated to 100° C. (212 F.) After the patient has had a brief period of sleep, the midwife cleanses, with a bit of absorbent cotton, the skin of thighs, abdomen and vulva, and wipes the surfaces dry with a clean, warm towel. Sponges have been for years banished from the clinic. The rules for the further treatment of the puerperal condition are :—

1. A rapid healing of the uterine wound is best effected by quiet, restricted diet and absolute cleanliness. To maintain cleanliness it is seldom necessary to inject lukewarm water into the vagina, and still more rarely are we compelled to irrigate the uterine cavity.

2. To prevent the absorption of the pus secreted by the uterine surface (*a*) fill all the bloodvessels to their maximum capacity, by the exhibition of generous quantities of lukewarm, sweetened drinks; (*b*) avoid depletion by diuretics, diaphoretics, or purgatives.

3. Secure uterine contraction during the third stage of labor and in the early hours of puerperium, even if no *post-partum* hemorrhage is threatened. This rule is especially imperative during the existence of epidemics of puerperal fever. Uterine contractions may be secured by massage of the abdomen and fundus, application of the binder or the exhibition of ergot.

4. Puerperal ulcers of the genitals, caused by the irritant action of the lochial secretion upon the traumatic effects of labor, must be rendered proof against the absorption of pus, during the first eight days, by the local application of potassium permanganate, basic sesquichloride of iron or tincture of iodine.

5. To arrest the fermentation process in the blood, or to limit its pernicious tendencies, five to fifteen grains of quinine may be exhibited daily with advantage. Axillary temperature of 39° C. (102 F.), pulse frequency of 100, dysphoria, constitute indications for the immediate use of the drug.

The Exchange of Gases in Fever.—Lilienfeld has recently conducted some experiments on the exchange of gases in animals in a state of fever. (*Pflüger's Archives*, Bd. XXXII., pp. 293-356.) The experiments were made in such a way that he was able to determine during a long period the interchange of oxygen and carbon dioxide—(1) when the animal's temperature was normal, and (2) when it was thrown into a state of fever by the injection of a putrid infusion of hay. He found that, without exception, both the absorption of oxygen and excretion of carbon dioxide were increased in fever, and also that the influence of the fever was greater in an animal which had been starved than in one which was fed up to the time of beginning the experiment. This difference he refers to the fact that in the last case the sudden cessation from feeding would alone diminish the amount of oxygen required. He also found that the ratio of the carbon dioxide expired to the oxygen inspired was not altered by the fever. This constancy of the respiratory ratio CO^2:O proves that Senator's assumption, that in fever the processes of oxidation are incomplete, cannot be accurate; but that the amount of tissue change is increased in fever, whilst the processes of oxidation are carried on in the same manner as in health, but to a greater degree. This increase of the processes of oxidation cannot be a consequence, but must be the cause, of the rise of temperature, since it took place in animals injected with the hay infusion, although their temperature was prevented from rising by keeping them in a bath at a suitable temperature. In one experiment even, in which the temperature of the animal's body was kept below normal by means of the bath, the interchange of gases was increased, this being probably due to the artificial cooling causing a compensatory increase in the production of heat. The author here again agrees with Finkler that the body has the power of regulating its production of heat in a state of pyrexia, as well as in health. Lilienfeld agrees with Zuntz that the rise of temperature, so far from being a salutary reaction of the animal's body in order to destroy the cause of the fever, is rather prejudicial to it, and at the same time favorable to the development of the pyrogenic organisms.—*Centralblatt fur Klinische Medicin*, January 19th, 1884.—*Medical Times & Gazette.*

CANADA

Medical and Surgical Journal.

MONTREAL, APRIL, 1884.

THE TREATMENT OF DIPHTHERIA.

If any proof were needed of our feebleness in dealing with diphtheria, it would be found in the great number and variety of the medicinal agents that are being constantly recommended for the treatment of this disease. Seldom a year passes without the publication of a new "specific." The latest agent that is confidently said to possess this power is corrosive sublimate. It is recommended to be applied locally, and used also internally. Locally, it is applied in the strength from $\frac{1}{1000}$ to $\frac{1}{4000}$. Internally, it is administered in the usual doses. Judging from the marked antiseptic properties possessed by this mercurial compound, it would appear, if the prevailing notions on the pathology of the disease are correct, to be the agent, above all others, that would be likely to do good. From recent experimental investigations, it has been abundantly demonstrated that of all our antiseptics, corrosive sublimate is the one which is the most powerful and at the same time freest from untoward effects. This only applies, however, to its power in destroying the micro-organisms of putrefaction, and not to the power that it may possess over the "micrococcus" of diphtheria. Although it has not been as yet proved, it is highly probable that diphtheria is due to the deposition in the affected tissues (mucous membranes) of a micro-organism; that the disease is, in the first place, a local one, and that its constitutional effects are secondary to the local changes which take place in the mucous membranes, and to the absorption into the blood of the micro-organism. Even if this view of the nature of the disease be the correct one, and even if corrosive sublimate proves to be our most powerful manageable antiseptic,

it does not by any means follow that we have in this agent a cure for diphtheria. It is impossible, in practice, to carry out the antiseptic treatment of a diphtheritic sore throat in such a manner as thoroughly to destroy all the infected tissues, even were we able to apply our remedy in the pre-exudation stage, and if impossible in this early stage, how much more so must it be when the mucous membrane becomes covered with membranous patches. Probably the most important local use of any of our antiseptic agents is the influence they exert on the mucous membrane in the neighborhood of the infected patches, and not on the diseased parts.

In the local treatment of diphtheria, something is wanted in addition to an antiseptic. We want an agent that is capable of rapidly dissolving the membranous patches. Two substances have been introduced into practice during the last two or three years, which have been confidently said to possess this power. These are papayotin and pilocarpine. The former acts by directly dissolving the exudation, while the latter, it is said, floats the patches away by giving rise to an exudation of serum on the surface of the mucous membrane. The papayotin is applied locally; the pilocarpine is given internally. In a certain measure both these agents fulfill what is said regarding them. Owing, however, to the great difficulty and expense in obtaining the papayotin, it has not yet been used sufficiently to demonstrate what degree of usefulness it does possess. The untoward effects which are apt to follow the free use of pilocarpine will always render it a dangerous remedy, when given in the doses necessary to produce its full physiological effects on the salivary glands. Unless it produces free salivation, it cannot be of any use in "flushing" the throat; and in the doses necessary to produce these effects, it acts more or less as a cardiac depressant. A cardiac depressant is, of all agents, one to be used with the extremest caution in diphtheria. There are several deaths recorded from heart failure in diphtheria where pilocarpine was administered, and where it was supposed to have had more or less share in bringing this about.

A recent writer speaks very highly of the success which he

found follow the treatment of diphtheria by the internal administration of corrosive sublimate in the usual medicinal doses.

It is highly improbable that corrosive sublimate can have any beneficial action when used internally. All of it that can with safety be introduced into the blood cannot exert any antiseptic influence, and it is inconceivable that it can act in any other way.

McGILL UNIVERSITY—ANNUAL CONVOCATION.

The annual convocation of the Medical Faculty of McGill University took place on the 29th March, in the William Molson Hall, which was crowded to overflowing on the occasion. The proceedings having been opened with prayer by the Ven. Archdeacon Leach,

Hon. Justice Mackay delivered the following address respecting the late Chancellor of the University, Hon. Justice Day :—

Since we last met in convocation a great loss has fallen upon the University by the death of our late Chancellor—the Hon. Mr. Justice Charles Dewey Day. He was its first chancellor under the amended statutes of 1864, and for thirty-two years was president of the Royal Institution for the Advancement of Learning. He continued actively to discharge the duties of those offices until his death, which occurred in England in January last. He had in his lifetime filled several positions of honor in this Province ; he was solicitor-general, and one of the chiefs practising at the bar of this city when, in 1845, he was offered and accepted a seat in the Queen's Bench, of which he continued to fulfil the duties until 1857, when he was appointed (we may truly say by reason of his fitness) one of the commissioners to codify the laws of Lower Canada. As a judge, the deceased was remarked for his practical energy, his great talent for despatch of business, and for analysis, his soundness of judgment, and his impartiality. He frequently presided at jury trials, which in his time seem to have been resorted to more frequently than nowadays ; his charges to juries, and these are things that sometimes try judges, were remarkably practical, lucid, sound and judicial. In 1864, upon the completion of the codes, which will ever remain a monument of his and his colleagues' industry

and learning, Judge Day retired from the bench; but he never ceased to interest himself in the affairs of this University, whose growth and progress, from very small beginning, he was witness of and powerfully contributed to. When he took office the students in arts numbered three, in the law faculty four, and in medicine fifty-three. In 1883 the students in arts numbered: undergraduates, 99; partial and occasional, 58,—in all, 157. The students in law numbered 26, in medicine 204, and the school of applied science was working with students, undergraduates 55, partial and occasional 14—together 69. In 1881, when the financial condition of the University was discouraging, the late chancellor, assisted by our worthy principal, prepared a statement of its affairs, accompanied by an appeal to the public for aid. This he supported by an eloquent speech at a public meeting. The result, as you know, was encouraging; friends of the University seemed to be *raised up*, liberal donations were made to it, and it was relieved from its embarrassment. At the first meeting of the governors after the melancholy news of Judge Day's death reaching us, it was resolved:

"That the governors of McGill College deeply lament the irreparable loss which this University has sustained in the death of their late colleague, the Hon. Charles Dewey Day, for thirty-two years the President of the Royal Institution for the Advancement of Learning and first Chancellor under the amended statutes of 1864, and one of the earliest and most valuable members of this Board.

"The history of the University is intimately bound up with the long course of his administration, and its progress and prosperity in a great measure are due to his eminent ability and the wise counsels that have at all times been rendered by him to promote its interests and welfare.

"The governors desire to record the high appreciation and esteem they feel for the great worth of his private and public character, the memory of which will be ardently cherished with reverence and affection by those whose privilege it has been to be personally and officially connected with him."

And at the meeting of the corporation of the University, held yesterday, a resolution of like substance was unanimously agreed to. The resolutions referred to free me, in a degree, from saying some other things that I might have said. I am confident that they will be approved by each and every person present in

this hall and by all who take interest in the affairs of the University, as a true and just tribute to the memory of an old and faithful servant of it, a worthy man, the blank left by whose decease it will be very difficult to fill up.

DR. HOWARD, Dean of the Medical Faculty, then read the awards of prizes and honors in medicine, as follows:—

The total number of students registered in this Faculty during the past year was 207, of whom there were from Ontario, 110; Quebec, 49; Nova Scotia, 5; Manitoba, 1; New Brunswick, 22; Prince Edward Island, 5; Newfoundland, 2; West Indies, 3; United States, 10.

The following gentlemen, 40 in number, have passed their Primary Examination on the following subjects: Anatomy, Practical Anatomy, Chemistry, Practical Chemistry, Materia Medica and Pharmacy, Institutes of Medicine, and Botany and Zoology. Their names and residences are as follows:

J. H. Armitage, Newmarket, O.
H. S. Birkett, Hamilton, O.
D. A. Cameron, Strathroy, O.
D. Corsan, Woodstock, O.
J. L. Clark, Waterloo, Q.
M. A. Craig, Glen Water, O.
W. C. Crocket, B.A., Fred'ton, N.B.
W. W. Doherty, Kingston, N.B.
John L. Duffett, Leeds, Q.
John Elder, B.A., Huntingdon, Q.
Thos. M. Gairdner, Bayfield, O.
J. B. Gibson, Cowansville, Q.
Geo. J. Gladman, Lindsay, O.
J. H. Y. Grant, Ottawa, O.
Smith Gustin, London, O.
P. H. Hughes, Strathroy, O.
John A. Kinloch, Montreal, Q.
Ed. P. McCollum, Duart, O.
W. J. McCuaig, Vankleek Hill, O.
H. J. McDonald, Alexandria, O.
Thos. G. McGannon, Prescott, O.
J. W. McMeekin, Chesterfield, O.
J. M. McKay, River John, N.S.
Guy F. Palmer, Ottawa, O.
Alf. T. Platt, Picton, O.
N. G. Powne, Nashville, Tenn.
W. P. Pringle, Cornwall, O.
G. H. Raymond, B.A., Springfield, [N.B.
A. Raymond, Moulinette, O.
F. D. Robertson, Lennoxville, Q.
W. M. L. Rowat, Manotic, O.
A. T. Schmidt, Faribault, Minn.
F. J. Seery, Fredericton, N.B.
W. A. Smith, Montreal, Q.
A. Russell Turnbull, Russell, O.
W. W. White, B.A., St. John, N.B.
F. J. White, Green's Pond, Nfld.
Charles Wilson, Cumberland, O.
D. J. Wishart, B.A., Madoc, O.
A. N. Worthington, Sherbrooke, O.

The following gentlemen, 34 in number, have fulfilled all the requirements to entitle them to the degree of M.D., C.M., from the University. In addition to the primary subjects as mentioned above, they have passed a satisfactory examination, both written and oral, on the following subjects: Principles and Practice of Surgery, Theory and Practice of Medicine, Obstetrics and Diseases of Women and Children, Medical Jurisprudence and Hygiene, and also Clinical Examinations in Medicine and Surgery conducted at the bedside in the Hospital:—

J. L. Addison, West Flamboro, O.
Jos. A. Barrett, Fenagh Vale, O.
Hy. J. Clarke, Pembina, Dakotah.
John R. Church, Aylmer, Q.
Sheldon E. Cook, Aultsville, O.
T. B. Davies, New Edinburgh, O.
John A. Duncan, Duncanville, O.
E. J. Elderkin, Apple River, N.S.
W. A. Ferguson, B.A., Richibucto.
C. E. Gooding, Barbadoes, W.I.
Geo. A. Graham, Hamilton, O.
Jas. A. Hutchison, Goderich, O.

C. H. Johnson, Almonte, O.
W. G. Johnston, Sherbrooke, Q.
Patrick N. Kelly, Rochester, Minn.
Thos. H. Landor, London, O.
J. H. McLellan, Summerside, P.E.I.
J. P. McInerney, Kingston, O.
Wm. McClure, B.A., Lachute, O.
G. N. McLean, B.A., Pictou, N.S.
John C. Meahan, Bathurst, N.B.
David B. Merritt, B.A., Ottawa, O.
W. M. F. Nelson, Montreal, Q.
Timothy O'Brien, Brudenell, O.
Wm. Porteous, Pembroke, O.
W. Scott Renner, Jordan Station, O.
L. D. Ross, Montreal, Q.
Geo. B. Rowell, Abbotsford, Q.
R. F. Ruttan, B.A., Napanee, O.
E. H. Smith, Prescott, O.
W. A. De W. Smith, Montreal, Q.
H. E. Smyth, Worcester, Mass.
Felix D. Walker, Launching, P.E.I.
S. F. Wilson, M.A., Springfield, N.B.

Of the above gentlemen, Messrs. Hutchison and E. H. Smith are under age, and await their majority before receiving the degree. Messrs. W. Johnston, Church and McClure await the completion of four years from the date of matriculation before receiving the degree.

The following have passed in Anatomy and Practical Anatomy:—J. E. Gray, F. H. Orton, V. H. Morgan, J. F. Williams, A. F. Schmidt, L. H. Carter, and Walter C. Cattenach.

The following have passed in Chemistry:—S. W. Boone, K. Cameron, Douglas McG. De Cow, E. H. Earl, J. Graham, A. Grant, T. J. Haythorne, A. D. McMillan, J. G. Owens, L. G. M. Pomeroy, Alf. Poole, L. F. Ross, B.A., W. G. Stewart, G. C. Stephen, and H. P. Wilkins.

In Practical Chemisty:—E. H. P. Blackader, S. W. Boone, W. D. Brown, — Cunningham, D. McG. De Cow, J. D. Flagg, G. C. Gardner, J. E. Gray, R. A. Kennedy, R. C. Kirkpatrick, Eug. McKay, V. H. Morgan, T. H. Orton, L. E. M. Pomeroy, A. Poole, — Ross, A. F. Schmidt, G. C. Stephens, and H. P. Wilkins.

The following have passed in Materia Medica:—L. H. Carter, D. McG. De Cow, J. E. Gray, T. J. Haythorne, R. A. Kennedy, — Kirkpatrick, V. H. Morgan, Eugene McKay, J. G. Owens, F. H. Orton, Alf. Poole, L. F. Ross, G. C. Stephen, A. F. Schmidt, H. P. Wilkins, and J. F. Williams.

The following have passed in Physiology:—L. H. Carter, D. McG. De Cow, J. E. Gray, H. V. Johnstone, R. A. Kennedy, V. H. Morgan, Eug. McKay, G. A. McMillan, F. H. Orton, A. Poole, L. F. Ross, B.A., A. F. Schmidt, G. C. Stephen, and Jas. F. Williams.

The following have passed in Medical Jurisprudence:—F. H. B. Allan, T. H. Armitage, R. H. Arthur, P. Aylen, T. A. D. Baird, J. A. Barrett, F. N. Burrows, L. H. Carter, A. W. Campbell, G. A. Cassidy, W. C. Cattenach, D. Corsan, W. G. Daly, J. H. Darey, B.A., H. Daze, D. W. Eberts, W. A. Ferguson, B.A., F. G. Finley, Wesley Groves, Smith Gustin, E. O. Hallett, A. Hanna, H. T. Hurdman, R. T. Irvine, C. H. Johnson, H. D. Johnson, Wm. H. Klock, H. J. Macdonald, N. McCormack, Wm. McClure, B.A., M. C. McGannon, J. T. Mackenzie, J. H. McLellan, J. W. McMeekin, D. L. McMillan, D. T. McPherson, D. F. Merritt, Alex. B. Osborne, J. G. Owens, G. F. Palmer, A. T. Platt, F. H. Powell, — Robertson, R. F. Ruttan, B.A., J. L. Shibley, B.A., H. E. Trapnell, F. Tupper, J. A. R. Wilson, and E. G. Wood.

The following have passed in Hygiene:—J. H. B. Allan, T. H. Armitage, R. H. Arthur, T. A. Baird, G. W. Boggs, W. Bowen, B.A., F. Burrows, A. W. Campbell, L. H. Carter, A. Cassidy, W. G. Cattenach, D. Corsan, M. A. Craig, W. S. Daley, J. H. Darey, B.A., H. Daze, W. W. Doherty, D. W. Eberts, F. G. Finley, J. D. Flagg, W. Groves, E. Hallett, A. E. Hanna, F. Harkin, R. F. Hurdman, R. T. Irvine, H. D. Johnson, H. V. Johnstone, W. H. Klock, J. L. Mattice, H. McCormack, H. J. McDonald, M. F. McGannon, J. McClellan, J. McMeekin, — McMillan, D. F. McPherson, A. B. Osborn, J. G. Owens, G. F. Palmer, A. T. Platt, L. E. M. Pomeroy, B.A., F. H. Powell, A. M. Robertson, J. L. Shibley, B.A., G. C. Stephen, H. E. Trapnell, J. A. K. Wilson, and E. G. Wood.

The following have passed in Pathology:—J. H. P. Allan, P. Aylen, T. H. Armitage, R. H. Arthur, T. A. D. Baird, J. A. Barrett, F. N. Burrows, A. W. Campbell, D. H. Cameron, L. H. Carter, G. A. Cassidy, W. C. Cattenach, D. Corsan, M. A. Craig, W. S. Daly, H. Daze, J. H. Darey, B.A., D. W. Eberts, W. A. Ferguson, B.A., F. G. Finlay, Smith Gustin, W. Groves, A. Hanna, E. O. Hallett, F. M. Harkin, H. T. Hurdman, H. V. Johnstone, H. D. Johnson, W. H. Klock, W. McClure, B.A., W. McCormack, M. C. McGannon, J. H. McClellan, J. W. McMeekin, H. J. McDonald, D. L. McMillan, D. T. McPherson, D. P. Merritt, Alex. B. Osborne, J. G. Owens, G. F. Palmer, A. T. Platt, F. H. Powell, — Robertson, R. F. Ruttan, B.A., J. L. Shibley, B.A., H. E. Trapnell, J. A. R. Wilson, and E. G. Wood.

The following have passed in Physics:—J. P. Aborn, J. A. Berry, G. W. Boggs, D. J. Flagg, J. M. Fraser, A. W. Gardner, L. E. M. Pomeroy, W. P. Pringle, M. G. Powne, S. W. Boone, K. Cameron, J. Boyd, W. Christie, A. W. Cowie, W. M. Donald, C. L. Easton, C. J. Edgar, W. E. Ellis, E. J. Evans, E. Fillimore, A. J. Grant, W. Hall, A. G. Hall, C. W. Haenstchel, E. D. Holden, J. M. Johnson, J. A. Kelly, H. A. Lafleur, D. D. McDonald, A. D. McDonald, G. C. Richardson, A. F. Ritchie, D. L. Ross, A. F. Schmidt, D. J. Scully, D. Sinclair, G. C. Stephen, W. G. Stewart, J. F. Williams, S. P. Williams, H. P. Wilkins, and T. G. Norman

The following have passed in Botany:—*1st class*—N. G. Powne, J. A. Dickson, S. J. Norman, J. M. Fraser, Wm. Hall, E. J. Evans, D. D. McDonald, E. J. Edgar, A. D. McDonald, N. R. Pringle, D. J. Scully, A. W. Haentschel, and S. P. Williams. *2nd class*—J. A. Ferguson, W. M. Donald, J. W. Johnson, C. L. Easton, J. A. A. Kelly, J. F. Brunet, A. M. Cowie, G. L. Richardson, D. L. Ross, — Aborn, W. G. Ellis, F. Loucks, and A. G. Hall. *3rd class*—D. Sinclair, H. McKinnon, F. W. Fillimore, — Boggs, J. J. Cameron, E. L. Quirck, J. A. Berry, J. Boyd, Wm. Bowen, A. L. Hamer, W. D. Parker, C. J. Polthier, W. D. S. Ferguson, A. H. Davis, A. B. Giles, J. P. Aylen, R. F. Ritchie, and A. F. Woodruff.

The following have passed in Histology:—P. Aylen, J. A. Berry, G. W. Boggs, S. W. Boone, Wm. Bowen, J. Boyd, K. Cameron, W. Christie,

A. W. Cowie, D. McG. DeCow, J. A. Dickson, W. M. Donald, C. J. Edgar, W. E. Ellis, E. J. Evans, J. A. Ferguson, W. D. Ferguson, E. Fillimore, J. D. Flagg, J. M. Fraser, A. W. Gardner, J. E. Grey, A. G. Hall, W. Hall, C. W. Haentschel, A. L. Hamer, J. W. Johnson, P. N. Kelly, F. Loucks, B. A. Lafleur, D. D. McDonald, A. D. McDonald, I. J. Norman, W. D. Parker, L. G. M. Pomeroy, N. G. Powne, W. P. Pringle, D. L. Ross, G. C. Richardson, D. Sinclair, D. J. Scully, — Williams, F. A. Woodruff, H. D. Wilkins, and — McKinnon.

Medals, Prizes and Honors.

The Holmes Gold Medal for the best examination in the Primary and final branches was awarded to Wm. A. Ferguson, B.A., of Richibucto, N.B.

The prize for the best final examination was awarded to Jas. P. McInerney, of Kingston, N.B.

The prize for the best Primary examination was awarded to Smith Gustin, of London, Ont.

The Sutherland Gold Medal was awarded to John Elder, B.A., of Huntingdon, Q.

The following gentlemen, arranged in order of merit, deserve honorable mention :—

In the Primary Examination—N. G. Powne, H. S. Birkett, J. A. Kinloch, J. Elder, B.A., W. W. White, B.A., W. J. McCuaig, W. C. Crockett, B.A., G. H. Raymond, B.A., John L. Duffet, C. W. Wilson, F. J. Seery, Geo. B. Rowat. A. R. Turnbull, E. P. McCollum, and G. F. Palmer.

In the Final Examination—Geo. A. Graham, R. F. Ruttan, Wyatt D. G. Johnston, Edwin J. Elderkin, and Thos. B. Davies.

Professors' Prizes.

Botany—Prize, N. E. Powne, of Nashville, Tenn. For the best collection of plants—Prize, J. E. Gray, of Coldstream, Ont.

Practical Anatomy—Demonstrator's Prizes: 2nd year, H. S. Birkett, of Hamilton, Ont. 1st year, D. L. Ross, of Winthrop, Ont.

Pathology—Prize awarded to Edwin C. Wood, of Londesboro, Ont.; and honorable mention to Fred. G. Finley, Montreal, Q.

The degrees were then conferred by the Ven. Archdeacon Leach, the formalities being gone through with in the usual manner.

Dr. J. P. McInerny, of Kingston, Ont., was then introduced, and delivered a very exhaustive valedictory address on behalf of the graduating class.

PROF. GEO. ROSS, A.M., M.D., was next called upon, and delivered an address to the graduating class. (*See page* 513.)

THE CAMPBELL MEMORIAL FUND.

DR. HOWARD, Dean of the Medical Faculty, before the meeting concluded made the following announcement:—For the information of the numerous friends of the University and of the Medical Faculty, I have much pleasure in stating that the movement begun in the session of 1882-83 to raise an endowment fund for the purposes of medical teaching and to commemorate the name of our late lamented dean, Dr. Geo. W. Campbell, has been successful. The subscriptions to that fund amount to $51,575, and a building lot worth about $700 to $1,000, and some of our friends have yet to be heard from. This generosity on the part of the friends of medical education enabled the faculty to call upon the Hon. D. A. Smith to redeem a promise that, in the event of $50,000 being subscribed as a Campbell Memorial Fund by the 1st of August, 1883, he would present the faculty with a like sum. I am sure that you will be pleased to hear that on the day that Mr. Smith was shown the list of subscribers to the Campbell fund he sent a cheque to the Dean for the amount promised, and thereby created the "Leanchoil Endowment" of the medical faculty. We are very grateful to him, not only for the munificent gift of money, but also for the influence his promise, given at the very outset of our undertaking, exercised upon many of our generous subscribers. These moneys are administered by the Board of the Royal Institution in the interests of the medical school.

The faculty of medicine of McGill University avails itself of this, its first public opportunity, to acknowledge also the services rendered to medical education in this province, the grateful tribute paid to the memory of its late Dean, and the substantial benefit conferred upon this university, by another distinguished citizen, Mr. George Stephen.

A day or two after the announcement of the medical faculty to raise a Campbell memorial fund, Mr. Stephen sent word that he would give $50,000 to the Montreal General Hospital to

commemorate Dr. Campbell's memory, and bonds to that amount were paid over in November last to that institution for the purpose of erecting a Campbell wing or building, and in which the professor of clinical surgery of McGill College should always have beds for teaching clinical surgery.

The medical faculty is very grateful to the many generous friends who have given such practical evidence of their good will.

CANADA MEDICAL ASSOCIATION.—The next meeting of this Association will be held in this city on the 25th, 26th and 27th of August next. Lawson Tait, Burdon Sanderson, and a number of other distinguished English scientists will be present.

BRITISH ASSOCIATION FOR THE ADVANCEMENT OF SCIENCE.—From *Science* we learn that Sir Joseph Hooker has been nominated one of the vice-presidents for the Montreal meeting of the British Association. Instead of Mr. Crookes, Prof. W. G. Adams will give one of the public lectures. A well-attended meeting of the organizing committee of the chemical section has been held, under the presidency of Prof. Roscoe. Promises of papers were received from several well-known chemists, and a small executive committee was formed to draw up a list of papers and to communicate with Canadian and American chemists. A list of subjects for papers in the engineering and mechanical sections has been prepared, particularly with the view of being treated by Canadians. Sir J. H. Lefroy has accepted the presidency of the geographical section. Prof. Burdon Sanderson has consented to act as deputy for Prof. Williamson, the treasurer.

—Dr. Lachapelle, one of the professors of Laval branch in Montreal, has made a very serious charge against the authorities of the Victoria Medical Faculty. He states, through one of the evening papers, that the professors of the latter school gave information beforehand to the candidates for the degree of the questions which would be asked at their written examination. He declares that he has documentary evidence of the correctness of this statement. The President of Victoria has denied the

charge, claiming that some of the papers were fraudulently obtained by some of their students. As the matter remains still to be investigated, we refrain from further comment.

—A move is once more being made to revive the project for a Protestant Insane Asylum for this Province. It seems to be in good hands, and we do hope will succeed: not because we think Protestant and Catholic lunatics require to be separated, but because there is *no* medical treatment in our present Provincial Asylum, and this, we trust, in the new Institution, will be looked upon as of the first importance.

—The annual meeting of the Association of American Medical Editors will be held in Washington on May 5th at 8 p.m. The annual address will be delivered by President Leartus Connor, M.D., on "The American Medical Journal of the Future, as Indicated by the History of American Medical Journals in the Past." Dr. N. S. Davis will open the discussion on "How far can Legislation Aid in Elevating the Standard of Medical Education in this Country?" All members of the profession, especially journalists and authors, are invited to be present and take part in the meeting.

Obituary.

LANSFORD P. YANDELL, of Louisville, Ky., one of the most prominent physicians in the United States, died recently at his home from angina pectoris. He was a physician of very high attainments, and had a good reputation as a writer and teacher. He was senior editor of the *Louisville Medical News*, and a prominent member of the American Medical Association.

DR. CASPAR WISTAR, of Philadelphia, who formerly occupied a very prominent position in the profession of that city, died on the 17th of March, at the advanced age of 75 years.

GEORGE ENGELMANNS, the accomplished physician and eminent botanist, died in February at his home in St. Louis, just after the completion of his 75th year.

Medical Items.

—The celebrated Berlin physician, Prof. Frerichs, has been raised to the order of nobility. This is the fourth physician who has lately received the honor, the others being Von Langenbeck, Ranke and Lauer.

—Drs. McLean and Duncan, of Fergus Falls, Minn., have recently been appointed surgeons to one district of the St. Paul, Minneapolis & Manitoba Railway. Their many friends will be glad to hear of their increasing success in this western country.

—Dr. Weichselbaum of Vienna says that he has discovered tubercle bacilli in the blood of a patient affected with acute miliary tuberculosis. They were not numerous, and care had to be exercised in order to find them, yet they undoubtedly existed. If this proves to be true, it will give us a valuable means of arriving at a certain diagnosis in these cases. Tubercle bacilli have also been found in the blood in cases of tuberculous meningitis.

—It is high time for the profession to throw over, once for all, the foolish pedantry of writing the directions in a prescription in a language which ninety-nine out of a hundred prescribers are utterly ignorant of, even in its canine variety. The most obstinate Latinists at the College of Physicians probably agreed with us when they came across the following prescription by one of their members in last week's *Lancet:*

"℞ Infusi foliorum recentium saxifragæ, ℥ iii
(Faciat et aqua calida xcviii Fahr., per boras sex; foliorum, 1; aquæ, x.)
Glycerini, - - - - - - - - - ℥ i Misce.
Fiat injectionem, ut bis die utendum."

There is considerable naïvete about that prescription.—*Times.*

—At a meeting of the Society of Physicians in Berlin, on February 13th, Dr. Siegmund read the history of a case of chyluria in a man aged 45. The filaria was not present in this case, and Siegmund did not believe in it as a cause of chyluria. In the discussion which followed the reading of Siegmund's

paper, Senator remarked that for several years he had a patient with chyluria under observation. Senator's patient was born in Germany, but had lived for a number of years in the Rocky Mountain regions of America—in a region where mosquitoes and other insects ("Greenheads") were very common. Senator said that recently Hirsch and Ewald said that mosquitoes bore a certain relation to tropic chyluria.

—The question has been raised as to the frequency of epilepsy in the colored race by the remark of Lawson Tait in a discussion as to deafness in white cats: "Every kind of white animal that I have kept as a pet has proved to be the subject of epilepsy, and the association is suggestive, when we are told, as I have been frequently, that the disease is unknown among negroes." A. G. Bell, in a recent communication in *Science*, says that so far as the American negro is concerned this is not true. Another writer in the same periodical maintains that epilepsy is more frequent in negroes.

—The occurrence of a distinct form of micro-organism in the sputa of pneumonic patients has recently been demonstrated by Drs. Poel and Molan, of Holland, thus confirming the experiments of Friedländer and others. Poel found these organisms in great abundance in the pneumonic exudations of the lower animals, and also in exudation present in the lungs in the human subject. These micro-organisms are micrococci, and are identical both in man and the lower animals. The identity of the virus in the pneumonia of men and the lower animals has further been proved by the cultivation and innoculation of each, producing identical results.

—Dr. E. H. Bartley, chemist to the Brooklyn Board of Health, has made a report to that body in regard to the "rock and rye drops" which, although flavored with fusel oil, are constantly sold at the candy shops in large quantities to school children; and in it he says: "In some of these candies the oil is not thoroughly mixed or diffused, and occasionally a good-sized cavity is filled with fusel oil. Estimating that a child may buy

and eat half a pound of this candy, containing 5–7 grains of the oil, it will be seen that it will take the maximum dose for an adult, and will probably experience distinct symptoms, such as dizziness, headache, or even slight intoxication." A fatal dose of fusel oil is stated by the best authorities to be from 1.4 to 1.6 grammes, or the quantity found in two pounds of this candy.

—During the year 1883, 606 cases of diphtheria were admitted into the Hôpital Trousseau, in Paris; 165 of these were pharyngeal, and 441 affected the larynx or air passages. The mortality in the pharyngeal cases was 40 per cent.; ten of the cases dying from paralysis, and the remainder from the toxic effects of the diphtheritic poison or some intercurrent disorder. The proportion of paralytic cases is very large, and the mortality extremely high. Of the 441 diphtheritic croups, 359 were operated upon, with 244 deaths, a mortality of 68 per cent. The 359 cases operated upon included 40 cases of croup complicating measles, and 30 who were under two years of age; and amongst those who recovered after tracheotomy, there was an infant of 13 months, three under 20 months, and two which were complicated with measles. The cases which were not operated upon were for the most part those cases in which there was widespread diphtheria of both pharynx and larynx, and which were moribund when admitted. These results have been the most satisfactory that they ever had in the Hôpital Trousseau. It is interesting to note that several cases of paralysis occurred after *laryngeal* diphtheria, thus pointing strongly to the identity of laryngeal diphtheria and membranous croup.

—Dr. T. D. Crothers, Secretary American Association for the cure of Inebriates, Editor *Quarterly Journal of Inebriety*, Hartford, Conn., says:—"BROMIDIA: This remedy or combination is peculiarly fitted for the cases who come under our care, and those who are working with inebriates and opium cases, of all others, should be made familiar with it."

CANADA

MEDICAL & SURGICAL JOURNAL

MAY, 1884.

Original Communications.

PUERPERAL ALBUMINURIA—ECLAMPSIA—INDUCTION OF PREMATURE LABOR—RECOVERY.

By H. N. VINEBERG, M.D., Portage La Prairie, Manitoba.

The subject of this communication (F. C.) is a married woman, aged 30, of medium stature, rather stout, and of a nervo-sanguine temperament. During the spring of 1883 I treated her for mitral insufficiency, which was causing œdema of the lower extremities. I then made several examinations of her urine, and found it normal. While under treatment, she was taken with a subacute attack of rheumatic fever (her second attack, the first occurring six years previously), which ran a tedious course, but from which she made, however, a good recovery. During the following summer she enjoyed good health, better, she said, than she had for years; the œdema of the feet and legs disappeared, and she experienced no trouble whatever from her heart. She became pregnant, and she dated her pregnancy somewhere about the beginning of June, "but possibly not earlier than the first," as her husband had been absent from home until then.

On December 10th I was summoned to see her. I found her suffering from a sharp pain at the pit of the stomach, shooting through to the back, and from nausea and vomiting. She had been in the best of health and spirits until the night of the 8th, when the above symptoms set in, after a two hours' drive, and to that she attributed her ailment. On the 14th, she was not much better, having received only temporary benefit from the opium

and soda powders I had prescribed. I now gave her grs. v each of Pulv. Kino. Co. and Bismuth Trisnitrate. This had the desired effect, and at my visit on the following day she was attending to her household duties. The pain, nausea and vomiting had entirely left her, and she said she felt quite well. I had asked for a specimen of her urine at my first visit, but only got it on the morning of the 15th. It was of an amber color, sp. gr. 1025, and on boiling and the addition of nitric acid, it became half solid. On close enquiry, I learned that her feet and legs had been swollen for some time, and, lately, that she had noticed swelling of the hands and face occasionally, but that she had not at any time suffered from headache nor dizziness. There was no swelling of the face and hands at the time of my enquiry. I put her on Basham's mixture, gave her ɱv of Tincture of Digitalis three times a day, enjoined her to live principally on milk, and to take ʒss of Rochelle salts every other morning.

December 18th.—At 3 a.m. I received an urgent message from her. On my arrival, I learned she had been very well during the day, but that at 11 p.m. she was seized with a violent headache, which she tried to combat by domestic remedies, and that it was only at 2 a.m., when. she lost her vision, that she became alarmed, and decided on sending for me. She was quite sensible, with a bounding pulse of 72 (her natural pulse-beats being from 54–60). I was scarcely in the room five minutes when she was seized with a slight convulsion, and in a few minutes afterwards she had another, which was general, and tolerably severe. While away getting remedies she had a third severe seizure. It was 3.45 when I returned, and from then until 5.15 a.m. she had two more severe attacks, which appeared to be shortened by the administration of ether. I at once gave her a hypodermic injection of a ¼ gr. of morphia. At 5 a.m. I cleared out the rectum by a copious enema of warm water and soap suds, and introduced a gum-elastic male catheter, without the stilette, into the uterus, endeavoring not to injure the membranes. I put a couple of drops of croton oil on the back of her tongue. At 7 a.m., as she was very restless, and complaining a great deal of headache, and as there was considerable vomiting, I gave her

another hypodermic injection of gr. ½ morphia. At 11 a.m. the headache had left her, but the vomiting and the amaurosis still continued. I now gave her chloral grs. xx, Pot. Bromid. 3ss per enema. At 2.30 p.m. I repeated the above enema, and gave a ¼ gr. of morphia hypodermically. The bromide and chloral enema seemed to check the vomiting, so that at 5.30 it had ceased entirely. The sight now began to return. She could discern objects, but could not distinguish them. Prior to that the loss of vision was complete. At 9.30 p.m. labor set in, the child's breech presenting, in the dorso-posterior position. In half an hour afterwards she was delivered of a living male child. There was moderate hemorrhage, which was easily controlled by ergot, and the placenta came away fifteen minutes after the birth of the child.

Everything progressed favorably from this on; her vision was completely restored the following day; the stomach grew tolerant of nourishment, but on the 20th she was taken with a slight attack of parametritis. This lasted for three days, the temperature ranging from 101° to 103°F. during that time. The urine was withdrawn with a catheter for the purpose of testing, and was found to contain 50 per cent. of albumen (that is, on boiling, and on the addition of nitric acid, it became half solid). The child lived for eight days, and, until within a day or two of its death, cried lustily and partook of a fair amount of nourishment. Had the weather not been so cold (30° below zero), and with an experienced nurse, I think it could have been reared without any difficulty. The patient, though somewhat thrown back by the death of the child, steadily improved, and was allowed to sit up on the 6th of January. The urine at this time was of a high color (sp. gr. 1040), and contained about 10 per cent. of albumen. She was passing about 30 oz. daily. I made weekly examinations of her urine after this, and the quantity of albumen kept diminishing only gradually, so that even now (April 3rd) there is still a trace of it present. She has been feeling very well, and has had no untoward symptoms since her getting up. During the past fortnight, however, she has noticed slight swelling of the feet and legs at night-time, which disappears in the morning.

The treatment consisted at first in the administration of the potash salts in an infusion of digitalis; later on, of Basham's mixture. The bowels were kept free by saline purgatives; the diet was bland and nourishing, consisting chiefly of milk; and after she was allowed to get up, she was given daily a hot air bath.

Remarks.—The publication of the above case may, I think, be of some interest to the readers of this Journal in connection with the much-mooted point, whether or not we are justified in inducing premature labor in similar cases. It is unfortunate to the ordinary practitioners, far away from the leading medical centres, that there should be a division of opinion on so vital a subject. It tends to make him uncertain in his course in a class of cases which are trying under any circumstances, and the success of which depends in a great measure upon immediate and decisive measures. The treatment of puerperal eclampsia has recently engaged the attention of the Montreal Medico-Chirurgical and New York Obstetrical Societies. The discussion at the former Society arose principally upon the question of bleeding; some were in favor of venesection in certain cases, while others had more faith in hypodermic injections of morphia, but the question of inducing labor was not broached. The course adopted in the case which opened the discussion, and in the cases referred to by the speakers, leaves the inference that, in Montreal, the profession is in favor of leaving nature alone, resting satisfied with the endeavors to allay the violent nervous symptoms for the nonce. But, as in all the cases mentioned, a still-born fœtus (in our case "a dead fœtus, much decomposed,") was expelled from one to four weeks after the onset of the convulsions, the lesson of the inutility of waiting upon nature to terminate gestation was forcibly illustrated.* If the life of the child is not saved, why expose the mother to the risks and dangers of a second outbreak of convulsions? Are these not greater than those of bringing on labor by the simple and comparatively safe means of "catheterization of the uterus"?

Those who took part in the discussion at the New York Ob-

* CANADA MED. & SURG. JOURNAL, January, 1884.

stetrical Society were decidedly averse to bleeding. The President, Dr. C. D. Lee, thought that patients with puerperal convulsions were too liable to be over-treated. In his opinion the induction of premature labor and narcotization during convulsions by hypodermic injections of morphia constituted all the treatment that was necessary.*

I recollect recently reading of an axiom laid down by Dr. Lee that in puerperal albuminuria, on the first appearance of severe nervous symptoms, labor was to be brought on. Lusk† expresses himself almost in the same language. "My own convictions are clear, that, so soon as grave cerebral symptoms develop, the period of folded hands has passed." Further on he says, "So far as my own experience goes, however, the practice of waiting upon nature has proved uniformly disastrous, while the induction of labor has furnished me with a certain proportion of recoveries."‡

Playfair thinks "the operation (induction of labor) is unquestionably indicated, and is perfectly justifiable in all cases attended with symptoms of gravity."§

We thus see that modern opinion is in favor of the induction of labor on the first appearance of grave nervous symptoms. Nearly all writers agree as to the value of hypodermic injections of morphia in controlling the convulsions, and in the case which forms the basis of this paper, I was much struck with the beneficial effect of the enemata of the bromide and chloral in checking the troublesome vomiting. The persistence of the albuminuria in my patient puts an aspect upon these cases which does not appear to have been taken notice of in the discussions and text-books referred to. By leaving the progress of pregnancy to nature, does not the danger arise of laying the foundation of a chronic disease of the kidneys?

I am now (April 3rd) treating a primipara for puerperal albuminuria, who was delivered of a female child on the 18th of February. My friend and colleague Dr. Higginson, who attended her during my absence, did not notice anything unusual during

* *New York Medical Journal*, December 1, 1883.
† Lusk, Science and Art of Midwifery, page 536.
‡ *Ibid*, page 538.
§ Playfair's System of Midwifery, p. 184.

the labor. There certainly were no nervous symptoms. A few days after delivery she had a sharp attack of pelvic cellulitis, which underwent satisfactory resolution in from ten to fourteen days. Still the patient was not growing strong, and had a couple attacks of unaccountable vomiting. These excited Dr. Higginson's apprehensions. He withdrew a specimen of her urine, which, on examination, was found to contain 50 per cent. of albumen. Then, for the first time (nigh three weeks after delivery), did swelling of the hands and face appear. During the last months of pregnancy I repeatedly enquired of the patient's mother if she noticed any swelling in her daughter's hands and face ; to which she always replied in the negative, and said "she was getting very well, though rather costive." The latter was relieved by daily enemata. I may here state that the patient has a fair complexion, and is rather of a phlegmatic temperament. The urine still contains about 25 per cent. of albumen, in spite of rest in bed, hot air baths, a milk diet, and the medicines that are usually administered in such cases. This case, apart from showing the tendency of puerperal albuminuria becoming chronic, has taught me the lesson of the necessity of making routine examinations of the urine of pregnant patients.

LETTER FROM BERLIN.

(From a Special Correspondent.)

I was not prepared to find Berlin so much changed in the ten years which have elapsed since my former visit. In every direction, improvements and reforms have been effected. The drainage system has removed the unsightly and odorous gutters, the streets are well paved and kept clean, and the newly erected public buildings are exceedingly ornamental, and offer a striking contrast to the general hideousness of the older ones. In the Medical Faculty of the University many important changes have taken place. Death has removed Traube, Martin and Reichert, and Langenbeck no longer rules the surgical clinic. Leyden, from Strasburg, was called to succeed Traube, Schrœder from Wurzburg has Martin's post, and Waldeyer from Strasburg has only recently occupied the chair of anatomy so long held by

Reichert. Bergman followed Langenbeck at the University surgical clinic. These are the changes in the front rank, and the men whom we all know by name; there have been many others, of course, among the extraordinary professors and privatdocents. The recent rapid development of the Berlin school, and the tendency towards centralization, have, doubtless, been powerful influences in causing the lavish expenditure of money on laboratory and hospital buildings. The new buildings of the surgical clinic on Ziegel Strasse, and of the Obstetrical and Gynecological Department on Artillerie Strasse, are the chief additions to the hospitals, though the new City Hospital on the other side of the town has also been opened since 1873. From my window, as I write, I look over the palatial buildings on Dorotheen Strasse, devoted to Physiology, Pharmacology and Physics, unequalled in Europe. At the Charité and the Pathological Institute I see no special changes.

Through the kindness of our townsman, Dr. Richard Lomer, 2nd assistant at the clinic, we have had an opportunity of seeing the new Obstetrical and Gynecological Hospital, opened in September, '82, which consists of a main building devoted chiefly to diseases of women, and four pavilions for the lying-in wards. There are about 50 beds in each department, a small number apparently, considering the extent of the buildings. The outdoor clinic is a very large one, and about 1800 obstetrical cases are attended in the city, chiefly by midwifes, who, when in difficulty, send for one of the resident students, who, in turn, if unable to manage the case, calls in one of the assistants. A curious custom prevails of paying the midwives so much (three shillings) for each case sent into hospital. From the gynecological clinic the patients are selected for the wards, chiefly operative cases. Professor Schroeder has complete control of both departments, but, of course, a very large amount of the work and responsibility fall on the assistants, who are skilled men, often remaining for years in the hospital. On the 12th of April we saw an abdominal section performed by Prof. Schroeder. A limited number of students or physicians only are asked to each operation, and certain preliminary precautions—such as bathing

and changing the clothing—are requested to be taken. He operates at 7 a.m., believing that this time of the day is better for both surgeon and patient. Stringent antiseptic measures are taken. The spray is not played directly on the patient, but is in one corner of the room, and directed over the table. The operator and his two assistants put on special linen overalls and jackets. The instruments are all taken from carbolic solution, 1 to 20, and the same strength is used for the hands. The patients are anæsthetized with chloral-chloroform, the sort used almost exclusively here. Ether is never employed. The case was believed to be one of uterine fibroids, but turned out to be retro-peritoneal cancer of the sacral and lumbar glands, which had extended in the pelvis along the sides of the rectum. There was a quantity of colloid substance in the peritoneum, very similar to that sometimes seen in ovarian cysts. Nothing could, of course, be done; the abdominal wound was closed with silk ligatures, inserted by means of large full-curved lance-pointed needles. In addition, coaptation sutures were used. An iodoform gauze dressing was then applied by means of adhesive plaster. On the 16th, Prof. Schrœder removed a uterus for malignant adenoma of the mucosa, which had been frequently scraped out, but had always returned; and on the same morning, a myomatous uterus from a woman who had been suffering for years with hemorrhages and pelvic trouble. In the latter operation, after ligating and cutting through the broad ligaments, a small Esmarch bandage was tied tightly at the lowest possible position, and the organ with the tumors removed. The larger vessels were tied, and the stump stitched with numerous silk ligatures inserted in rows; a surprising number were employed, and infinite pains taken to tie every bleeding point. The enormous thickness of the abdominal walls made the operation very difficult.

The operating room is comparatively small, not more than 25 by 16. No major operations are performed in the theatre.

In the obstetric department, tolerably stringent antiseptic precautions are used. Before delivery, and after each examination, the vagina is washed out with a 1 per 1,000 corrosive sublimate

solution. No special antiseptic napkins are used after delivery. A good plan prevails of entering in a book the name of every individual who has examined any patient. In event of an elevation of temperature, the speculum is used and intra-uterine injections practised, or, when deemed necessary, constant irrigation.

There is a portion of the building set apart for septic cases of all kinds, with a special assistant, nurses, &c. There are two delivery rooms, one of which only is used at a time. The obstetric wards are small, four beds in each. The building is magnificently finished, in a style worthy of the government which paid for it; nothing appears lacking. The entire building is lighted by Edison lamps.

The Easter vacation ended on the 16th April, and the work of the summer session began on the 17th.

QUARTERLY RETROSPECT OF OBSTETRICS AND GYNÆCOLOGY.

PREPARED BY WM. GARDNER, M.D.,
Professor of Gynæcology, McGill University; Attending Physician to the University Dispensary for Diseases of Women; Physician to the Out-Patient Department, Montreal General Hospital.

Corroding Ulcer of the Os Uteri.—At the meeting of the Obstetrical Society of London on March 5th, 1884, Dr. John Williams read a paper on this subject. He spoke of the rarity of the disease, and the want of description of it in systematic works on diseases of women. Cancer is the disease with which it has been mistaken. Dr. Williams related the histories of three cases which had been under his observation for some time. One of these had been watched for two years, and two for ten years. Two were dead, the third still alive. The post-mortem characters and microscopical appearances in one case were described. The differences, anatomical and clinical, between this disease and cancer were described. Dr. Williams believes with the late Sir Charles Clark that the disease is distinct from cancer. It begins at the os uteri, and extends along the vagina in a symmetrical manner. It makes slow progress. Dr. Williams' patients died of some other disease. Loss of flesh is not neces-

sarily associated with it; the pain and discharges are different from those of cancer; the edges of the ulcer are not hard and thickened. In one of the cases the mode of progress was by means of reddish raised tubercles, which became ulcerated; in another case, it was by slow ulceration, without any preceding changes in the tissue about to be invaded, except redness. The mucous surface up to the edge of the ulcer appeared healthy, and this was confirmed by microscopic examination. During the discussion which followed, Dr. Matthews Duncan said he had given the disease special study for many years, but had never seen it affect the os. In his experience, it had always involved the lower part of the vagina. He believed it to be of the nature of lupus. Drs. Griffith and Routh had seen similar cases. In closing the discussion, Dr. Williams remarked that rodent ulcer is epithelioma, starting from the hair follicles and sweat-glands, and corroding ulcer could not be such an affection.—(*Brit. Med. Journal*, April 5, '84.)

Sulphate of Copper in Obstetric Practice.—M. Charpentier of Paris recommends this salt as an antiseptic in obstetrical practice. He has tested it, and arrived at the following practical conclusions: Solution of sulphate of copper at 100° acts both as an antiseptic and disinfectant; its use is agreeable to patients. It can be used for vaginal and uterine injections without the slightest danger or pain, even when there is erosion of the epithelium. It is a more energetic hæmostatic than iron perchloride. It may be used during the first eight or ten days, and applied several times a day if necessary. Lowering of temperature and slowing of pulse are the only results.—(*British Medical Journal, Paris Letter*, April 5, '84.)

The Treatment of Uterine Displacements by Medicated Tampons.—Some two years ago, Dr. Robert Bell of Glasgow published a paper on this subject. I took occasion then to embody the substance of the views and experience therein presented in one of these reports. The formula for the solution used by Dr. Bell was then given. In a paper read before the Edinburgh Obstetrical Society on Feb. 13, '84, the author gives the results of more extended experience of this method. He admits having

had reason to modify his views considerably, but emphatically asserts his increased confidence in this method in properly selected cases. He does not discard pessaries, but finds the remedy most valuable in the treatment of many cases of prolapsus and retroversion or retroflexion, with enlarged, congested and catarrhal cervix. The solution, it will be remembered, is one of alum and carbolic acid in glycerine, and a tampon saturated with it, the author claims, when properly applied, fulfils three indications: 1, It supports. 2, It depletes. 3, It invigorates the uterus and vagina. Dr. Bell asserts having cured many cases of displacements, prolapsus and retroversion that had resisted the use of pessaries for years.—(*Lancet*, Ap. 12, '84.)

Dr. Clifford Abbott of Leeds delivered the Gulstonian Lectures this year. He selected for his subject "Neuroses of the Viscera." The author is well known, especially to the readers of the early volumes of the *Practitioner*, during the period when it was edited by the late lamented Austie, to whom he was a kindred spirit, as an able advocate of the theory that a large, important and intractable class of common maladies which medical men are called upon to treat are of nerve-origin, and that if anything more than neurotic disorder occurs in their development, it is an effect, and not the cause, of the trouble the physician is called upon to deal with. These lectures March (15, 22 and 29, '84, *Lancet* and *Brit. Med. Journal*), by the able Lecturer on Medicine at the Leeds School of Medicine, make "for the first time a formal and broad affirmation" (*Lancet* leader, April 12, '84) of this most important fact. As the writer of a report on the progress of gynecology, I am especially charged with presenting to our readers the following statement: "Now, gentlemen, it is time we complete our reaction from this gynecological tyranny, and that we of this College no longer permit ourselves to be snubbed by these brethren of ours, who calmly tell us, with their superior airs, that our use of such expressions as uterine neuralgia, irritable uterus, ovarian neuralgia, neurasthenia, and the like, comes of a shallow sciolism, and is grounded upon the emptiness of our knowledge of uterine diagnosis. The spirit of meekness alone restrains me from

throwing the same stone again, and accusing our gynecological friends of ignorance of neuropathies and of the neurotic diathesis." In support of the point he attempts to make, the lecturer reports a number of cases of uterine trouble long under local treatment, but unrelieved, which were speedily relieved by general tonic treatment. It does not require a large experience of the diseases of women to teach the practitioner that many of them cannot be successfully treated by local measures alone; that to cure the patient there must also be the employment of measures calculated to improve the tone of the system generally. I have to commend these lectures to our readers. They will do much to correct a tendency on the part of some practitioners to excessive use of local measures in uterine and ovarian affections. Personally, I am grateful to Dr. Clifford Allbutt for reminding me forcibly of truths long ago learnt by experience, but the memory of which may be dulled by the habits and methods of a specialist.

Pilocarpine in Puerperal Eclampsia.—The use of this powerful diaphoretic in puerperal convulsions has been proved to be by no means always safe. Dr. Fordyce Barker has recently reported some unfortunate results. On the other side of the question may be adduced the report of two cases treated successfully with the drug by Dr. Murphy, of Sunderland, Eng. Dr. Murphy's report will be found in the *Am. Jour. Obst.*, Dec., '83. The Philadelphia *Medical News* for April 26, '84, contains the report of another by Dr. Marechal, of Stockton, Alabama. The woman, æt. 26, was in the ninth month of her third pregnancy, the two previous pregnancies having ended in abortion. Her symptoms were headache, vertigo, nausea, vomiting, watery diarrhœa, suppression of urine, and enormous œdema. The urine with heat and nitric acid became almost solid. Other remedies were tried for four days with little good result. Convulsions set in. One-fifth of a grain of the muriate of pilocarpine was administered. It produced excessive sweating and copious dejections from bowels and bladder, and after 24 hours of coma without return of fits, she regained consciousness. Two days later she was delivered of a living child after a short normal labor.

Iodoform as a Preventive of Uterine Colic and Pelvic Inflammation after intra-uterine application of Nitrate of Silver.—Dr. Selman read a paper on this subject before the Medical and Chirurgical Faculty of Maryland at its annual meeting last month. The writer finds that no remedy he has used is so efficacious in endometritis as a solution of silver nitrate, eighty grains to the ounce. He finds that perfect cure or great relief follows its use. Stricture or atresia of the uterine canal has never, in his experience, followed its use. But he has several times seen colic or pelvic inflammation follow. To relieve the colic, belladonna, opium and hyoscyamus he had found ineffectual. Knowing the anæsthetic effect of iodoform he had used that and hitherto with unvarying success. His method is to make the application of the nitrate of silver solution on a cotton-wrapped applicator, and to follow it immediately with powdered iodoform applied in the same manner or by means of the uterine iodoform bougie.—(*Phila. Med. News*).

Fungous endometritis is, in its various forms, a most important disease. Its true etiology is still somewhat uncertain.

Brennecke, in a recent number of the *Archiv für Gynakologie*, discusses the subject. Olshausen, it will be remembered, has also written ably upon it. Brennecke believes in two forms, a glandular, in which overgrowth of gland-tissue is the conspicuous change; and an interstitial, in which there is marked hyperplasia of connective-tissue. He describes six cases observed by himself, and refers to some other published cases. In all he finds a history of complete amenorrhœa or of irregular, frequent or scanty menstruation, preceding for some time the hemorrhage and other symptons characteristic of the disease. For these reasons he believes that the disease depends primarily on a functional disturbance in the ovaries, which as a reflex effect causes chronic hyperæmia of the uterine mucous membrane, and thus leads to hypertrophy of its structure. This reflex effect is produced through the nervous mechanism which governs ordinary menstruation, and it therefore affects the body only and not the cervix. Being due to reflex action, it cannot be cured, while the cause of the reflex effect remains

in operation. Hence the frequency of relapse. For treatment of this form he considers the curette to be the great remedy. Cauterization is of little avail. That form of the disease in which there are localized outgrowths Brennecke believes to be due to some other disease of the uterus, as chronic catarrh, simple or gonorrhœal; retroflexion, stenosis of the os internum or externum, interstitial or submucous fibroids. This he calls the uterine form. He points out the following distinctions: 1. In the uterine form there is hemorrhage from the beginning; in the ovarian, menstruation is at first deficient or absent; 2. In the uterine form there is scarcely any tendency to relapse; in the ovarian a strong tendency; 3. The fragments removed by the curette are smaller in the uterine than in the ovarian; 4. In the ovarian form these pieces show the structure simply of hypertrophied mucous membrane; this is seldom the case in the uterine form, in which the products of catarrh and ulceration are commonly found. The author points out the importance of distinguishing fungous endometritis following abortion from the other forms. He calls it the decidual form. In this latter form the results of treatment are most satisfactory. One curetting usually completely cures.—(*Am. Jour. Med. Sc.* from *Med. Times & Gaz.*)

Simultaneous Operations for Lacerations of Cervix Uteri and Perineum.—These operations are now frequently performed at one sitting. Experience has demonstrated the perfect safety of the plan, and the advantages to the patient are obvious. Dr. Janvrin of New York reports a series of fifteen successful cases of the double operation in the April ('84) number of the *American Journal of Obstetrics*. As Dr. Janvrin remarks, an hour and a half usually suffices for the completion of both operations, and this is usually quite a safe duration of etherization. In a recent instance, I completed both operations in one hour and twenty minutes. The perineal sutures are removed on the eighth day, and the cervical on the eighteenth to the twentieth. With care this can be done in a good light with a long narrow-bladed Sims' speculum without danger to the integrity of the newly-formed perineum.

Ignipuncture in Uterine Disease.—This remedy has for some time been popular in France and some other continental European countries in the treatment of indurated hypertrophy, or, as Dr. Thomas would have it, hyperplasia, with or without profuse catarrh or ulcerations of the cervix. Courty, whose work has recently become known to English readers through Dr. Agnes McLaren's translation, is a strong advocate for it. Dr. Prochownick of Hamburg writes a paper for the April number of the *American Journal of Obstetrics*, in which he gives the results of a most favorable experience of it. He does not advocate its substitution for Emmet's or Schröder's operations, as these cannot be replaced in suitable cases by any other procedures, but discusses it as an alternative measure in the treatment of swollen hypertrophied vaginal portion. He believes that in such cases it may be a valuable substitute for the wedge-shaped excision and amputation of the vaginal portion. The patients, after ignipuncture, are not confined to bed, and this is a great advantage in the case of the poor in dispensary practice. The author's method is to apply the ignipuncture every 10 or 14 days—two punctures to the anterior and two to the posterior part of the *portio* with a pointed galvano-cautery or Paquelin. In hypertrophy without catarrh, the punctures are made centrifugally from the vaginal surface to the lining of the cervix; when there is profuse catarrh, the punctures are made from within the cervix outwards. Before and after the puncture disinfectant irrigation is practised, and afterwards a tampon laid over the cervix. The first effect is to cause increase of swelling of the cervix for a few days. The subsequent reduction of size goes on for some months. The author reports forty cases thus treated, without a relapse.

The significance of Metrorrhagia recurring about and after the Menopause.—This is the title of a recent paper by Dr. B. F. Baer, Instructor in Clinical Gynecology in the University of Pennsylvania. The author begins his paper by saying that "Metrorrhagia, recurring about the menopause, is as likely to be the result of disease in the uterus, or its appendages, as it is at any period previous to that time. The popular belief that

flooding at the change of life is physiological often results in harm, and should be discouraged. But many physicians also believe that profuse hemorrhages are often necessary at the period of the menopause ; that the blood-loss is depuratory or critical, and that it protects the vital organs from injurious or even fatal congestion." The author goes on to say that he thinks this to be erroneous ; for if it were true, many more cases of metrorrhagia would be met with at this period, or more women would suffer and die from cerebral or other internal congestions, as a result of the absence of hemorrhage. Statistics show that this is not the case, but, on the contrary, that in those women in whom the cessation is gradual, and without more than the ordinary menstrual flow, better health is enjoyed then and afterwards, than when these so-called critical floodings occur. When health exists, the cessation of menstruation will be attended by no more aberrations of function than are seen in its establishment. Temperament and idiosyncrasy are modifying factors, but where deviations from the normal standard are marked and persistent, they should be regarded as pathological and the cause sought for. Those women who suffer at puberty and at the catamenial periods are almost certain to suffer at the menopause, and the cause is usually found to exist in an imperfectly developed sexual system and a nervous susceptibility. Where puberty and menstruation have been normally established and performed, and where much suffering is experienced at the change of life, the cause will very generally be found in a pathological condition of the uterus or ovaries, the result, probably, of injury at parturition, which may or may not have given rise to symptoms previous to the period of life at which menstruation usually ceases. Dr. Baer reports a number of cases, the histories of which show that hemorrhage at and after the menopause is almost invariably a consequence of uterine disease, such as cancer or fibroids, or the less serious engorgement from the remains of old pelvic peritonitis or cellulitis, which cause displacements or otherwise act as irritants, or interfere with venous return-flow of blood. I think the paper one well deserving the study of every practitioner, as it must tend to modify the erroneous ideas to which

the author alludes at the commencement of his paper.—(*Amer. Jour. Obst.*, May, 1884.)

The Operation of Ovariotomy: A Lecture delivered before the Fourth Class Students in the Harvard Medical School, by John Homans, M.D., Surgeon to the Massachusetts General Hospital. The lecturer stated that he had opened the abdomen for various purposes 203 times, and that he had performed ovariotomy 159 times. His first five ovariotomies all died. They were done without antiseptic precautions of any kind. In the next 100 cases of ovariotomy, with antiseptic agencies, including spray, 87 recovered. Since then he has operated 54 times, with four deaths. His last 30 have all recovered. He has never but once declined to operate. In the preparation of the patient he restricts her diet for 48 hours previous to operation to flour gruel, made by boiling equal parts of milk and water together for an hour, gradually adding the flour until the gruel is made smooth and free from lumps. As regards the time to operate, he prefers two days after the cessation of the menses, but has operated six times when there was hemorrhagic flow from the uterus, when it could not be avoided. These all recovered. He has found it necessary to tap a large cyst before operation, to enable the patient to breathe more easily, to take more food, to lie down, to secrete more urine, or to lessen her size and weight before she travels. In speaking of sponges, he says "about forty clean soft sponges of various sizes, which have been soaking for several weeks in a five per cent. solution of carbolic acid. I have three barrels filled with solutions of carbolic acid, and these barrels are kept full of sponges. Each barrel is used alternately. Some of my sponges have been soaking for ten years. I formerly used sponges but once, but I now use them over and over again after they have been cleaned." He always uses the steam-spray, but does not believe it essential, but has had good results and no harm from it. He prefers to operate with seven assistants, in this respect differing from Keith, Tait, Spencer Wells, and others, who operate with one or two assistants only, and these, if possible, always the same. Assistant No. 7 has a responsible duty; he oversees the spray and keeps tally upon

paper of the sponges placed in and taken out of the abdominal cavity. He prefers this method to that of counting the sponges after an operation. For compressing hæmostatic forceps, he prefers the small forceps (Duffenbach's pattern). To each one he ties a piece of small fishing line, 20 inches long, and attaches it to a little weight of lead. "When I see a bleeding point I pick it up with the little forceps and throw the weight and line over the patient's side. I attach this line in order that none of the forceps may fall into the abdomen if I knock them off. It is much easier to work through an opening surrounded by these little instruments than through one bristling with forceps, each one of which is five or six inches long." In the treatment of the pedicle, he first clamps it with Dawson's clamp, then passes through it a small needle threaded with a loop, on which hangs a long silk ligature. He then burns through the pedicle with Paquelin's cautery. After the tumor is thus separated, while the pedicle is still held by the clamp, he ties it with Tait's "Staffordshire knot." Like every other operator of note, he devotes a great deal of attention to the "toilet of the peritoneum." In sponging the spaces between the uterus and rectum and uterus and bladder, he uses Nelaton's cyst forceps as a sponge holder. In the after treatment, he says: "The cardinal principle in taking care of a patient after ovariotomy is to give opiates and stimulants by the rectum until flatus passes by the bowels, or until all symptoms of nausea or vomiting have been absent for many hours."—(*Boston Med. & Surg. Journal*, April 10, '84.)

Reviews and Notices of Books.

Transactions of the American Surgical Association. Vol. I.—Edited by J. EWING MEARS, M.D., Recorder of the Association, Philadelphia. Printed for the Association by Presley Blakiston, Son & Co. 1883; pp. 566.

This is the first volume of the transactions of the American Surgical Association, a society of recent origin, founded in 1880, with Dr. S. D. Gross as its first President.

The volume is a handsome one and the typography is excel-

lent. It contains thirty-two papers on surgical subjects, some of them of great length. Dr. Senn, of Milwaukee, takes up over a hundred pages with an exhaustive paper on "Fractures of the Head of the Femur," with special reference to bony union after capsular fracture.

Dr. P. S. Conner, of Ohio, has an interesting paper on "Excisions of the Tarsus," with a report of two successful removals of the entire tarsus. He shows clearly that the generally received opinion that extensive tarsal disease necessitates amputation, is one that requires reconsideration. He has collected 108 cases from various sources, and gives a very exhaustive analysis of them. This paper is one of the most valuable in the volume.

Dr. S. D. Gross, in a short paper, strongly urges the value of early operations in morbid growths.

Dr. James L. Cabell writes on the "Sanitary Conditions in Relation to the Treatment of Surgical Operations and Injuries." Dr. Briggs on the "Antiseptic Treatment of Wounds after Operations and Injuries," and Dr. B. A. Watson on "Lister's System of Aseptic Wound Treatment *versus* its Modifications."

Dr. Packard, of Philadelphia, reports a successful case of Ligature of the Common Iliac Artery, to relieve secondary hemorrhage after Amputation at the Hip Joint. We congratulate Dr. Packard on his successful case, but fail to see why he should have had secondary hemorrhage. Had he ligated in the modern way, that is, by employing an antiseptic ligature and cutting it short instead of leaving the ends of the ligature hanging out of the wound (a procedure which we thought had become entirely obsolete), we venture to say the necessity for this formidable operation would not have arisen.

Dr. S. W. Gross contributes a paper on the "Influence of Operations upon the Prolongation of Life and Permanent Recovery in Carcinoma of the Breast," another on the "Condition of Cicatrices after Complete Extirpation of the Breast," and also reports a case of "Nephrectomy for Medullary Sarcoma."

Dr. Kinloch reports a case of "Spontaneous Aneurism of the Posterior Tibial Artery," and gives a resumé of the literature

on the subject. It would be impossible to notice all the papers, but many of them are valuable contributions to our surgical knowledge. The weakest part of the volume consists of the discussions at the end of each paper. These are crude, uninteresting and often not at all to the point. The discussions following the papers on antiseptic surgery plainly show that most of the men taking part in them are wofully ignorant of the first principles of antiseptic surgery. They speak of that which they know not of and testify to (or rather against) those things which they have not seen. We should be sorry to think that their opinions truly represent the condition of American surgery. In future volumes of the Transactions we hope that these discussions will be omitted.

The Principles and Practice of Surgery: Being a Treatise on Surgical Diseases and Injuries.—By D. HAYES AGNEW, M.D., LL.D., Prof. Surgery, Univ. Pennsylvania. Vol. III. Philadelphia: J. B. Lippincott & Co. 1883.

The third and last volume of this surgery adds to the reputation achieved by the first two. In it are treated of, for the most part, what are at the present day known as *specialties*, a part of surgery which has, perhaps to their discredit, almost entirely passed out of the hands of the general surgeons.

The first six chapters are taken up with the Diseases of the Larynx and Trachea, Nose and Naso-Pharyngeal region, Eye and its appendages, Ear, Orthopœdics and affections of Muscles, Tendons and Bursæ. Chapters XXXII and XXXIII are devoted to Syphilis and Tumors. Both these subjects are simply and concisely treated of. Dr. Agnew strongly disapproves of a person who has once had syphilis marrying. He also believes that the regulation of prostitution comes legitimately within the province of civil law.

Dr. Agnew, in the treatment of a case of excision of the breast, still believes that strips of plaster are useful as well as silver sutures. He recommends very plain diet for the first three or four days, until the surgical fever (which he apparently always expects) is over. His cases generally take be-

tween three and four weeks to heal, but he mentions, as evidently a rare occurrence, that he has seen "recovery follow removal of the mammary gland in twelve days." In our experience this is about the average time of recovery. The last three chapters of the book are devoted to Electricity, Operations for Nerve Stretching, and Massage.

The two latter chapters are profusely illustrated and will prove very useful to practitioners. There is an index for Vol. III. as well as a general index at the end of the volume. This work, which is now completed, is one which will ever be the storehouse of valuable surgical facts. It, however, can hardly be said to truly represent modern surgery, as the author has evidently failed to grasp the great facts of modern antiseptic surgery, and seems to doubt that the splendid results achieved by it surpass those of what we may call "old-fashioned" surgery.

Clinical Chemistry.—By CHARLES HENRY RALGE, M.D., Asst. Physician at the London Hospital. Illustrated with 16 engravings. Philadelphia: Henry C. Lea's Son & Co. Montreal: Dawson Bros.

The fourth of the series of manuals for students. "Is an account of the analysis of blood, urine, morbid products, &c., with an explanation of some of the chemical changes that occur in the body in disease." In the first and second chapters, the proximate and ultimate composition of the principles of the animal body, and the nature of the processes which produce the various decompositions and variations, are considered. Then follows examination of blood, chyle, lymph, milk. The chapters on morbid conditions of the urine and digestive secretions are particularly recommended to clinical clerks for perusal.

Eczema and its Management. A Practical Treatise based on the study of 3,000 cases of the disease.—By D. BULKLEY, A.M., M.D. Second edition. New York: G. P. Putnam's Sons. 1884; pp. 344.

The fact that this book has come to a second edition is suffi

cient evidence of its popularity. We see very few changes in this new edition, the number of pages being exactly the same as first. As we very fully reviewed the first edition in 1882, we need say very little about the second more than that it fully sustains the well merited reputation of the author. We can honestly recommend this work to all those who desire to know something of that very common disease, Eczema; a disease which every practitioner of medicine is called upon to treat, and which is most often, of all skin diseases, ill-treated. A careful perusal of Dr. Bulkley's book will enable the physician to intelligently and successfully treat many cases of Eczema, which he before had thought to be incurable. The volume is well printed and furnished with a good index.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, February 29th, 1884.

WM. OSLER, M.D., 2ND VICE-PRESIDENT, IN THE CHAIR.

Unilateral Hyperidrosis and Tabes Dorsalis in a Female.—DR. REED read the notes of this case. (*See April number of this Journal, page* 534.)

DR. HY. HOWARD said that unilateral hyperidrosis is by no means uncommon in cases of mania in the chronic stage, particularly where there is partial sensory and motor paralysis. It is just what we should look for in these cases, if we bear in mind the experiments of Dr. Isaac Ott, from which he drew the following conclusions:—1, That the sensory fibres decussate in part in the spinal cord; 2, That the vaso-motor fibres also do; 3, That the sudorific fibres follow the vaso-motor and decussate; 4, That vaso-motors run in the lateral columns. Now, seeing that in nearly all cases of mania, particularly in the chronic stage, there is found some abnormal state of the different nerves, producing low temperature, etc., it is but natural that we should find hyperidrosis in these cases; but in the case brought under our notice by Dr. Reed, as yet there has been no pathological psychosis. But with the hyperidrosis, there is

absence of patellary reflex, showing some abnormal or degenerate state of the sensory or motor tracts in the cords, with enlarged and fixed pupil, showing a partially paralyzed state of the ciliary nerves. With these symptoms, I should say that there was some abnormal state of the spinal cord, or of the vaso-motor, sudorific and sensory nerves in their course along the sides of the cord, which time will more fully develop.

DR. OSLER had seen two cases of unilateral hyperidrosis during the past two years, one of which was in a patient suffering from caries of the cervical vertebræ.

DR. REED remarked that he, with Dr. R. P. Howard, was treating another case of tabes in a female.

PATHOLOGICAL SPECIMENS.

Actinomykosis.—DR. OSLER exhibited the jaw of a cow attacked by the above disease, often called "big-jaw," or osteo sarcosis, and due to a fungus, slides of which were also shown. The yellow color in the centre of the nodular masses was well seen. Dr. Osler said that this disease was fairly common in Europe and America, and has been known for a long time under a variety of names, such as tubercular stomatitis, scirrhus tongue, scrofula, etc. The tongue, lips and mucus membrane of the nose are often attacked. Actinomykosis is fatal unless removed with the knife. This disease is seen in the horse and swine, and even in man, twenty cases being reported, all in Germany. In man, multiple abscesses are generally produced throughout the whole body, a fatal issue always following.

Lack of Development in an Infant.—DR. TRENHOLME exhibited the above, which was born at full time in the Western Hospital. There was entire absence of the genital organs and pelvic bones. The abdominal wall was formed by the posterior wall of the bladder, on each side of which the ureters opened. The anus was covered with integument. The child lived four or five days.

Local Paralysis Agitans.—DR. MCCONNELL exhibited this patient and read the following history:—Fred. R., aged 34, was born in Cambridge, England. Since 20 years of age, has been

occupied as a railway engineer. Has always enjoyed good health, and he is not aware of any member of his family having suffered from any nervous affection. On 20th August, 1882, at Sacramento, California, his engine collided with that of another train, and he was thrown violently to the ground, falling on the top of his head. He was quite unconscious for ten weeks. He received a scalp wound on the top of the head, at which point there can now be felt a distinct depression. On returning to consciousness, he found his head done up in a kind of harness, which he soon after ascertained was intended to prevent an involuntary lateral and continuous motion of the head. He was treated in California and in various cities throughout the United States. He states that all kinds of treatment have been employed, such as blisters, actual cautery, electricity, trained exercise, &c., and endless medication, with no relief to the movements. *Present condition*—Is somewhat emaciated; very tall (6 feet 3 inches), and of light build, and appears very intelligent, speaking of his affection and the various methods of treatment in a humorous strain. There is a continuous rotation of his head from side to side—very regular when quiet, but increasing in frequency when he attempts to speak or perform any act, and ceases during sleep. When quiet, the movements are 103 times per minute. Frequently complains of pain over region of left temple. Has occasionally a slight discharge from left ear; for some time after the accident this was continuous. Is usually very restless during sleep, talking much and tossing about. Walks well, except when he has attacks of what, from his description, appears to be vertigo, accompanied with double vision; says sometimes single objects appear as if there were four. When one of these attacks occur, he usually has three or four in succession, occurring daily or every other day, thus a month or two might elapse before again experiencing any. They usually come on suddenly while walking, when he is unable to guide himself, and has frequently been locked up, his condition being mistaken for drunkenness. There are no symptoms of paralysis, as loss of sensation. From the symptoms of this case, I have looked upon it as one of local paralysis agitans, possibly symptomatic.

DR. ROSS referred to the article in Ziemssen's Encyclopædia on cases of clonic spasm. The writer there says that cases similar to this one of Dr. McConnell's are generally produced by blows on the back of the neck or head; the operation recommended being to divide the spinal accessory nerve or excise a portion. The prognosis is bad.

DR. TRENHOLME did not think it ought to be called paralysis agitans, and would suggest trephining over the depression.

DR. FOLEY had seen nerve-stretching performed for a similar condition.

DR. OSLER said the symptoms were not unlike those seen after removal of the vertical semicircular canals in pigeons.

In reply to Dr. Trenholme, DR. MCCONNELL said: If not paralysis agitans, what is it? According to the classification of the narration of the disease by Sanders in Reynold's System of Medicine, I certainly think it must come under that title. In regard to the suggestion made of trephining the skull at the point where the depression exists, with a view of curing the case, I think that result would hardly be attained. The movement is produced by alternate contractions of the sterno-cleido mastoid muscles, thus indicating some implication of the nervous structures at the origin of the spinal accessorius. I therefore think it a question whether treating the surface of the brain would have much effect on an apparently localized lesion in the upper end of the cord. In reply to Dr. Osler that it would be better classed as a case of multiple sclerosis, I may say that the fact of the affection occurring in one at his age, and being confined to the head, would favor that view; but, on the other hand, the definite movements occurring during rest, as well as during voluntary movements, and the fact that no paralysis exists as yet, although the tremor has lasted now a year and a half, are points which are generally supposed never to obtain in multiple sclerosis.

Stated Meeting, March 14th, 1884.

T. A. RODGER, M.D., PRESIDENT, IN THE CHAIR.

A groom sent by DR. GURD was exhibited to shew what appeared to be a clear case of accidental inoculation of horse pock

in the human subject. A dark colored scab, depressed in the centre, was to be seen a little below the outer corner of the left eye and the parts about, were red and swollen. One of the horses which he had the care of was suffering from horse pock, so prevalent in the city lately.

DR. PROUDFOOT shewed a specimen of epithelioma of the lower eyelid removed by him a few days ago.

DR. KENNEDY exhibited a small *Anencephalic Fœtus*, the deficiency also extending as a spina bifida downwards to the middle of the dorsal region. There are also an abdominal hernia, the protrusion being covered with the peritoneum only. At birth there was evidence that general peritonitis had existed for some time which no doubt had caused the death of the fœtus some days before delivery. The case was of some interest owing to the difficulty that arose during delivery. Dr. Kennedy gave the following history: The mother had passed through several pregnancies. Her first child was carried to full term, but the labour was difficult and only completed by instrumental delivery. Each successive labour terminated at the seventh month without any apparent cause, none of the children surviving. She came under my attendance with this last pregnancy, and at the time of engaging my attendance for her confinement, stated that a physician who had examined her had found an extensive laceration of the womb. No opportunity was given me of verifying this condition. Anticipating a recurrence of premature labour, rest and other precautions were taken to avoid its induction but without avail. I was sent for about the seventh month and found she had been in labour about twelve hours. On examination of the abdomen the fœtal body was felt to be lying in an oblique position relative to the mother's body. A vaginal examination showed the os to be fully dilated and a large amniotic sac distending the vagina. As no movements had been felt for some time by the patient and there being occasional discharges of blood, the membranes were ruptured. An immense quantity of amniotic fluid came away, followed by a free discharge of blood. Failing to find any part of the chlid presenting, and as the loss of blood was becoming serious, the hand

was passed into the vagina. The intention was to perform version at once, but owing to the pain it was thought best to retain the hand in the vagina as a plug to prevent loss and send for assistance. While waiting the placenta and cord were forced down into the palm of the hand, showing that the attachment of the placenta had been very low and that easy separation had taken place. Dr. Perrigo arriving, gave her chloroform. The hand was introduced into the uterus, which was found constricted in the middle. Dilatation of this constriction was slowly effected, and in the cavity above the fœtus was found and brought down by the feet. Delivery was speedily effected, the patient making a splendid recovery. This patient would, without doubt, have died from hemorrhage but for the promptness of assistance given her. The low attachment of the placenta may in some measure account for the deficient development of the fœtus.

Dr. Trenholme stated that in cases of lacerated cervix uteri the cause of abortion was not due so much to the laceration itself as to the diseased condition of organ induced by the lesion. The uterus was irritable and the altered state of the tissues hindered its normal development. The mere fact of lack of support was not enough to induce abortion, or we would meet with such more frequently than we do in multipara where, as is well known, a considerably dilated os was compatible with normal gestation. The reflected decidua effectually closed the womb, whether the os was lacerated or patulous as already stated.

Dr. Hy. Howard considered that there must always be a physical cause for a physical effect, and said it was the duty of scientific medical men to get at the cause of such deformities. He related a case in his own family of port wine mark due to a maternal impression.

Dr. Trenholme avowed his belief in the transmission of maternal impressions to the fœtus.

Dr. Proudfoot reported the case of a child born with one arm and one leg.

Dr. Wilkins remarked that Paget reports a case of a

child with deficient fingers, apparently due to the mother having handled a deformed hand during pregnancy.

DR. GEO. ROSS thought that only cases of irregularity were the remembered ones. He also reported a case of hydrocephalic fœtus with fusion of the fingers and toes.

DR. TRENHOLME exhibited two *Dermoid Cysts*, each attached to an ovary which he had removed on Saturday last. The left weighed two pounds and the right one pound. Both fallopian tubes were considerably dilated. The uterus, removed *post-mortem* and normal in appearance, was also shewn. The woman was aged 32, healthy, &c. Had suffered for many years, but especially since birth of last child, 5 years ago. Of late was unfit for duties of life and sought relief. Temperature and pulse continued most favorable for the first 24 hours, when pulse rose to 150, notwithstanding drop doses of veratrum viride, which was continued 8 or 10 hours. Twenty minims of Battley were given hypodermically in the evening to quiet the utterances of patient. She passed a quiet night and gradually sank, and died 44 hours after operation. Autopsy shewed limited but insignificant local peritonitis and some slight effusion. Heart was normal. The womb had healed by first intention throughout. The cause of death, while not clear, may be perhaps fairly laid to the veratrum viride, which may have caused the otherwise unaccountable collapse and death.

DR. KENNEDY remarked that he had seen two patients who seemed to have been affected injuriously by veratrum viride, and objected to its use in a case like this of Dr. Trenholme's.

DR. RODGER had observed great rapidity of pulse follow the use of veratrum viride.

DR. STEWART said that cardiac depressants as veratrum viride are contraindicated in puerperal cases.

Dr. ROSS related cases of great depression produced by veratrum viride in the Montreal General Hospital. Convalleria seemed also to have acted unfavorably in a recent case treated there.

DR. MACDONNELL exhibited photos of a patient the subject of an internal tumor. The cutaneous abdominal veins appeared excessively enlarged.

Slow Pulse.—DR. MIGNAULT related a case of slow pulse in a dyspeptic—treatment brought the beats from 38-48 to 70.

DR. WILKINS met with two cases where the rate per minute was only 45.

DR. STEWART had a case of 25 to the minute which, under atropine treatment, went up to 100.

DRS. MACDONNELL and ARMSTRONG also mentioned having seen cases of abnormally slow pulse.

Extracts from British and Foreign Journals.

Unless otherwise stated the translations are made specially for this Journal.

Milk Diet in Childhood.—That milk is the only proper food for infants is universally acknowledged. It is my purpose to consider in the following paper whether the exclusion of meat from the dietary of children under seven and eight years of age and the use of milk as the chief article of food are beneficial. The importance of the subject can scarcely be overestimated. Upon the proper nourishment of the child's body and the careful training of his digestive apparatus depend the good or ill health of the future man and, to a great extent, his ability to succeed in life's struggle.

Milk is now used in much larger quantities than formerly, not only by children but also by adults. But a pretty general underestimation of its dietetic value still prevails even among those who use it abundantly. Milk contains the elements necessary to the growth of the body, and is the natural food of the young of all the higher forms of animal life. "A distinguished chemist once remarked to me," says Sir William Jenner, "'Do not forget that a pint of milk contains as much solid animal matter as a full-sized mutton-chop.'"

It is unnecessary to give an analysis of the composition of milk. Such may be found in any work on dietetics. "Milk," says Pavy, "is complete in itself. In it exists, besides the organic principles, all the inorganic matter, including both salines and water, that is needed."

"The action of milk," says another writer, "is exceedingly

analagous to that of the cereals, and the combination of the two appears to be the most perfect kind of food."

We might very naturally infer that such a diet would be the best for children. It is with an appreciation of this that the temporary teeth, which begin to loosen and fall out at about the sixth year, are called milk teeth. At this age, too, the delicate mucous membrane of the stomach is not adapted for the meat diet of adult life. Who has not noticed that feverishness and fretfulness, and stomach and intestinal disorders, are common among children who eat largely of meat? In France it is not uncommon to give meat to very young children.

"In France," says an English writer, "children are often fed upon flesh meats when very young, but they are not so healthy as English, and mortality is greater." "My experience is," writes Dr. Clouston, "that children who have the most neurotic temperaments and diatheses, and who show the greatest tendencies to instabilities of brain, are, as a rule, flesh-eaters, having a craving for animal food too often and in too great quantities. . . . And in such children I most thoroughly agree with Dr. Keith, who, in Edinburgh, for many years, has preached an anti-flesh crusade in the bringing up of all children up to eight or ten years of age. I believe that, by a proper diet and regimen more than in any other way, we can fight against and counteract inherited neurotic tendencies in children, and tide them safely over the periods of puberty and adolescence."

Another writer, after urging the necessity of giving children an abundance of milk, continues enthusiastically:—"If this, or anything approaching this, were the rule instead of the exception, rickets in its manifold phases would be completely banished from this country, and a much higher standard of health and robustness would unquestionably prevail." The strapping gillie of the Scotch Highlands is brought up on oatmeal and milk, and he is "certainly not wanting in strength and muscular endurance. On the contrary, as every one will admit who has had to keep up with him in a hard day's deer-stalking, he is all wind and limb."

During the past twenty-five years, in a large institution in

this city, meat has been omitted from the dietary of children under eight years of age, and it must be admitted that this has been long enough to test fully the value of the diet adopted. It will be appropriate in this place to consider the dietary somewhat in detail. It will be given in full as adopted about a year ago by the Board of Managers. It is essentially the same as that adhered to for the past twenty-five years. The reason for formulating a new dietary was that some changes were about to be made in the management of the institution, and the Medical Board was therefore asked to state its views upon the subject. The report of the board contains the following :—" The past records of the institution furnish such ample proof of the value of milk and vegetable food, and the exclusion of meat from the dietary of children under eight years of age, that the Medical Board sees every reason to adhere for the future to the diet from which such good results have been reaped in the past."

DIETARY FOR CHILDREN UNDER EIGHT YEARS OF AGE.

From November 1st to May 1st.

Sunday, Tuesday and Friday.—*Breakfast*—Bread and milk.

Monday.—Oatmeal, steamed, and served hot with molasses.

Wednesday.—Hominy, steamed, and served hot with molasses.

Thursday —Mush, hot, with milk and sugar.

Saturday.—Wheaten grits, hot, with milk and sugar.

Sunday.—*Dinner*—Bread, milk, potatoes, cabbage, or pumpkin ; sago or rice pudding. *Supper*—Bread and milk.

Monday.—*Dinner*—Bread, milk, eggs, potatoes, parsnips, or spinach. *Supper*—Bread and milk, stewed prunes.

Tuesday.—*Dinner*—Bread, chowder of salt codfish, potatoes, crackers and milk, cabbage sprouts, or tomatoes. *Supper*—Corn starch, with milk and sugar.

Wednesday.—*Dinner*—Bread, milk, potatoes, onions, rice or bread pudding. *Supper*—Bread and milk, stewed apples.

Thursday.—*Dinner*—Bread, milk, eggs, potatoes, spinach. *Supper*—Mush and molasses.

Friday.—*Dinner*—Bean porridge, potatoes, parsnips, carrots, or turnips. *Supper*—Bread and milk, stewed peaches.

Saturday.—*Dinner*—Bread, milk, potatoes, cabbage, or onions ; apple sauce. *Supper*—Hominy, with milk and sugar.

From May 1st to November 1st.

Breakfast—Bread and milk.

Sunday.—*Dinner*—Bread, milk, potatoes, asparagus, or other fresh vegetables, salt bacon broiled, rice or sago pudding. *Supper*—Bread and milk.

Monday.—*Dinner*—Bread, milk, eggs, string-beans. *Supper*—Bread and milk, dried apples stewed.

Tuesday.—*Dinner*—Bread, chowder of salt codfish, potatoes, crackers and milk, tomatoes, fresh fruit. *Supper*—Corn-starch, with milk and sugar.

Wednesday.—*Dinner*—Bread, milk, salt bacon broiled, onions, rice or bread pudding. *Supper*—Bread and milk, stewed peaches.

Thursday.—*Dinner*—Bread, milk, eggs, potatoes, string-beans, fresh fruit. *Supper*—Mush and molasses.

Friday.—*Dinner*—Bean porridge or salt codfish, potatoes, tomatoes. *Supper*—Bread and milk, stewed apples.

Saturday.—*Dinner*—Bread, milk, potatoes, asparagus or other fresh vegetables, fruit. *Supper*—Hominy, with milk and sugar.

The following fruits may be given:—Strawberries, raspberries, peaches, pears, currants, blackberries, blueberries. No changes to be made in the dietary without the approval of the attending physicians. The report is signed by the Medical Board, Dr. J. R. Leaming, consulting physician, and Dr. Janvrin, Dr. McQuestin and Dr. Cammann, attending physicians.—

The medical reports have been usually short, and have not entered very fully into details. A few extracts, however, bearing upon the subject under consideration may be given. The report of 1862 says:—"From the antecedents of these children, being orphans, we might expect more or less constitutional tendency to disease—and such indeed is the fact; yet their general health will compare favorably with those enjoying the luxuries of their own happy homes. We owe much to the superior sanitary regulations adopted here, the facilities for bathing, the pure air, and, more than all the rest, the admirable bill of fare—plain, nutritious, bountiful, and yet unstimulating—well adapted to their age and wants."

Five deaths occurred in 1865. During this year meat was added to the dietary of the children, but the old diet was resumed at the end of the year.

During the year a great deal of sickness prevailed, mostly cases of diseases of the digestive organs. This may have been to some extent due to the sudden and marked changes of weather experienced during the early months of that year and the persistent high temperature prevailing through the summer months. Under the head of gastric derangements ninety-eight cases are reported, and only twenty-five cases under the same heading in

the previous year. It is somewhat significant that this was the only year during which the children under eight years of age had a meat diet. The report for 1866 says :—" The dietary, being founded upon principles having reference to the wants of the system at the tender age of most of the inmates, is, from that fact, of such a nature as to preclude most of the digestive derangements which are the fruitful sources of most of the more serious maladies."

The report of 1868 contain the following, which is only an echo of many similar reports in other years. It says that during the year there was " a very moderate share of the ordinary diseases usually prevalent in like institutions." The report of 1870 says :—" This is not the place to enter into a disquisition upon the causes of sickness among children, but it will be observed that, although we have many very young children, no cases of convulsions, gastric fever and intestino-spinal paralysis have occurred, for the reason that the chief cause has been avoided, viz., the ingestion of unwholesome and (for their age) indigestible food, the diet of such consisting entirely of bread, milk, farinaceous food and vegetables, no 'indulgent parent' being at hand to permit the bolting of meat and other substances unfitted for these stages of physiological development of their digestive organs." The report of 1873, after congratulating the Board of Managers on the few cases of sickness during the previous year, and the length of time that has elapsed since the last death, says :—" Truly this is something unusual when we consider the number of children in the institution, and of their tender years. Too much credit, however, cannot be given to the physician first connected with the Home, Dr. J. R. Leaming, and for the admirable rules which he established as to the diet of the children. To this one point we attribute, in a great measure, our exemption from serious sickness." The report of 1875 says :—" When we consider that the inmates are the children of parents who themselves lived in crowded and ill-ventilated houses, whose subsistence was unwholesome and still more poorly prepared, we can only see and wonder at the remarkable health in which proper sanitary, hygienic and dietary

measures may result." The report of the Medical Board for 1876 says:—"It is with feelings of great satisfaction that it now announces to you the continued good condition of all the inmates of the Home; this is especially satisfactory when we consider the debilitated condition of most of the children on their entrance into the institution. The majority are the descendants of those whose condition in life was so unfavorable to health that they are placed under our care already impregnated with the seeds of disease sown by vice and violation of all sanitary laws. . . . We should fail to do justice to the labors of our predecessors did we omit to acknowledge our indebtedness to them for their very perfect dietetic and hygienic system heretofore established and still continued with such favorable results."

The rarity of disturbances of the digestive organs has been especially worthy of remark. Diarrhœa and dysentery in the summer months are rare. For twenty-five years only one death has occurred from dysentery and one from cholera infantum, and these were in 1865, when meat was for a short time added to the dietary. During this year the cases of derangement of the digestive organs were increased nearly 300 per cent. over the previous year. Another matter worthy of note is the large percentage of recoveries from diseases which from time to time have invaded the Home. More than once has scarlet fever attacked a considerable number of the inmates, yet only two deaths have occurred from this cause in a quarter of a century. The general health and appearance of the children are exceptionally good. They are freer than is usual from colds and other slight ailments so common in the winter.

It has been my endeavor in this paper to avoid theorizing and to give a plain statement of facts, backed by twenty-five years of proof. I think that the experience gained during these years has shown not only that young children can do without meat, but that they become stronger and develop best without it; that they may thus escape many of the disturbances of the digestive organs and other troubles springing therefrom which are so common in childhood. Especially is the diet suitable in our

country, where disturbances of the nervous system, both inherited and acquired, are so common. Many man and women doubtless owe to-day good health and success, and even life itself, to its happy influence in early years.—*Dr. D. M. Cammann in New York Medical Journal*, March 29, 1884.

Gastrostomy in the Olden Times.—Dr. James Dixon, in a letter to the *Times* and *Gazette*, brings to light the following, which must prove of great interest to the surgical antiquary:

The patient was Andreas Gruenheide, a peasant of Gruenwald, near Königsberg. On May 29, 1635, wishing to induce vomiting, he took up a table-knife by the blade and with the handle tickled his fauces. The knife slipped from his hold, and after a short delay in the œsophagus entered the stomach. He tried the very simple plan of placing himself with his head downward, but finding that the knife did not stir, he went to Königsberg, and applied for advice to Dr. Becker. The whole *collegium medicum* of the city were invited to deliberate on the case, and a further opinion was requested from the medical faculty of Leyden. These learned doctors returned a solemn reply, divided into ten heads, finally sanctioning an operation. Dr. Becker encouraged the man to submit, by relating a similar case which had been successfully operated on at Prague, and then, on July 9th, handed him over to Daniel Schwaben, "Surgeon and Lithotomist." All present having joined in solemn prayer for success, the man was bound to a plank, and the surgeon made a vertical incision below the false ribs on the left side, two fingers' breadth long. This seems a very small opening; and, indeed, in all the three drawings it is represented as a full hand's breadth from end to end. Lakin speaks of the "two fingers breadth" as indicating the point below the ribs where the incisson was begun, not the length of the incision itself. The abdominal cavity having been opened, the stomach was caught up with a curved needle and drawn forward. In doing this the point of the knife was felt and cut down upon, then seized, and the knife drawn out. No attempt

was made to close the wound in the stomach, which is described as spontaneously shrinking together. The external incision was united with five sutures, over which a most fantastically compounded poultice was applied. Nutritive enemata, it seems, were not thought of, and some soup was taken by the mouth on the very day of the operation, and was followed up by a powder and mixture. The patient appears to have resumed his ordinary diet within a few weeks after the operation. The wound healed completely; the man regained his health, and in 1643 was married; the name of the bride and the date and place of the marriage being duly recorded by Dr. Becker in his MS. Another proof that the patient was living several years after the operation is afforded by a quaint entry in the diary of John Evelyn. He visited Leyden, and under date of August, 1641, describes his visit to the anatomy school, where, he says, "among other rarities I was shown the knife newly taken out of a drunken Dutchman's gut, by an incision in his side, after it had slipped from his fingers into his stomach. The pictures of the chirurgeon and his patient, both living, were there." In Becker's MS., in his book, and in Lakin's translation, the patient is shown with the incision in his abdomen; and in the margin the knife is depicted of its natural size. The blade and handle together measure about seven inches. Dr. Hagens, in concluding his paper, mentions the celebrated case of "*l'homme a fourchette*" at Paris, and Félicet's "*taille stomacale*" for extracting a spoon; Schwaben's knife, he adds, completes the *Besteck*.

Diphtheritic Dysentery Following Confinement.—At a recent meeting of the New York Pathological Society (*N. Y. Med. Jour.*) Dr. Janeway presented a large intestine the whole length of which was involved by diphtheritic inflammation, probably of not more than four day's duration. The interesting feature of the case was that it should have happened just after confinement. The woman was twenty-three years of age, a domestic, who was delivered of her first child on March 18th, at 6 p.m., labour being normal and lasting six hours. The temperature on the following morning

was 99°F., and remained at that point until the afternoon of second day, when it suddenly went up to 104.4°. And the uterus, which had contracted well after delivery, increased to a large size, extended above the umbilicus, and was flabby. There was a discharge from the vagina, somewhat colored, which was increased by pressure upon the uterus. There was no perceptible odor. Intra-uterine douches of bichloride solution, 1 to 2,000 were given when the temperature rose. On the night of the 22nd she had a number of diarrhœal movements, perhaps eight. These were afterwards controlled by suppositories of opium. On the last day of her life, although the temperature continued high and the heart-beat was comparatively strong, there was no pulse at ankle or wrist, and the hands were cold. She had taken full, but not excessive, doses of ergot. She had had morphine, whiskey, and quinine. At the autopsy there was found to be some diphtheritic endometritis, with some patches on the vagina, but the lesions were not so striking in the general tract as in the large intestine. There were no other lesions except slight parenchymatous nephritis and a large, soft spleen. The case was interesting, as it demonstrated that in some of these cases the intrauterine injections would not touch all the disease. In this case the lesions in the intestine had the appearance of being older than those in the uterus. It was further interesting as illustrating a point which Dr. Janeway had frequently remarked, namely, that simple inspection of the discharges would not always enable us to determine the absence of a serious diarrhœal disease; and even should a little blood or a few clots be found in the stools after delivery, they might readily be attributed to the lochia.

The Prevalence of Rickets in Glasgow.—For the second time within the last two or three years, attention has been drawn to the prevalence of rickets in Glasgow and its neighbourhood. On the present occasion, the matter was brought up at the last meeting of the Glasgow Philosophical Society, in the shape of a paper by Mr. James Thomson, the president of the Biological Section of the Society, and a well known geologist, The subject was treated under the two heads

of, first, the frequency of the disease; and, secondly, its relation to the food and water used. On the former point, abundant evidence was adduced as to the great prevalence of the disease, as shown by the number of deformed children seen in the streets, the results obtained being the fruit of several years of observation in the various localities of the city. When dealing with the second question, namely, the relation of the disease to the food and water used, Mr. Thomson brought out some curious but interesting statistics. He does not altogether blame Loch Katrine water, with its small amount of lime, as the cause of the mischief, though he evdiently regards it as a source of weakness to the growing members of the community, but he looks for an explanation of the present state of matters in the wrong system of feeding which is so much in vogue among the working classes, in which there is an excessive use of tea and sugar, to the almost total neglect of oatmeal. In fact, it was apparently brought out by the figures quoted that the prevalence of rickets in different localities bore some relation to the amount of oatmeal used. Another point on which Mr. Thomson also dwelt was the evil resulting from the supercession of oatmeal by fine flour, this last being so much less nutritious. He says, "both the miller and the baker not only foster, but pander, to the popular and delusive desire for white bread," which is "a mass of deception in the form of flour." In the course of the discussion which followed the reading of Mr. Thomson's paper, Professor McKendrick gave the weight of his opinion in favour of the view that the number of rickety children in large towns, such as Glasgow, is principally owing to the kind of food employed, and not so much in the water-supply. There can be no doubt that the foolish style of infant feeding so prevalent amongst our working classes has much to answer for in the frequency of rickets in our city populations; and if the public attention thus drawn to the matter leads to an increase in the use of oatmeal as an article of diet, and to the discontinuance of many of those "modern innovations which have supplanted the simpler and more natural arrangements of living," we would find rickets as a disease

less prevalent in our midst, provided due attention is also paid to those conditions, such as impure air, bad drainage, and careless nursing, which are so favourable to its development, apart from the question of food supply.—*Brit. Med. Jour.*

Endarteritis and Gangrene of the Limbs in Typhoid Fever.—The cause of the arterial obstructions sometimes observed in typhoid fever has been the subject of much discussion and of numerous researches during the last few years. Some authors, adopting Hayem's opinion, tried to prove that thrombosis of the arteries is the result of their obliteration by an embolus coming from the heart; but this organ is sometimes found quite healthy, and a paper published recently by Dr. Barrié in the *Revue de Medicine* goes far to support an opinion already expressed by Patry de St. Maure, according to which the obliteration is due, in nearly all cases, to endarteritis. Dr. Barrié, who bases his conclusions on careful observations and necropsies, states that typhoid fever may produce two forms of endarteritis, the obliterating and the parietal. Both are characterized anatomically by an infiltration of all the coats of the artery with embryonic cells; the internal coat loses its polish, and in the obliterating form the blood coagulates at the diseased spot and plugs the vessel; in the parietal form, small clots are found on the internal coat, but the circulation is not arrested. These lesions occur most frequently in the arteries of the lower extremities, but they may be found also in those of the upper limbs, in the carotid, the arteries of the heart, liver, spleen, etc. They are due, according to Dr. Barrié, to an inflammation of the arterial walls, and to a vaso-motor paralysis consequent on the presence of micro-organisms in the blood. They appear generally about three weeks after the onset of the disease. The symptoms of the obliterating form are violent pains along the artery, which is hard and tender to the touch, diminution or disappearance of its pulsations, swelling of the limb without œdema or redness, and diminution of the temperature; after some time, dry gangrene of the limb generally supervenes, and amputation may be

required; the prognosis of the operation is of course very unfavorable, but some successful cases have been recorded by Lereboullet, Patry, and others. In the parietal form there is also pain along the artery and swelling of the limb, but the vessel does not feel indurated, the pulsations are often increased at first and then diminished; the temperature of the limb is generally lower but sometimes higher than on the sound side. After a few days the symptoms disappear, and in most cases the patient recovers completely.—*Brit. Med. Jour.*

The Micro-Organism of Acute Infectious Osteomyelitis.—Dr. Becker has made, in the laboratory of the Berlin Imperial Sanitary Office, a series of important experiments on the micro-organisms discovered by Schuller and Rosenbach. He collected pus from five cases of acute osteomyelitis in which the abscesses had not been opened, and cultivated the micrococci contained in it on sterilized potatoes, coagulated serum, and gelatine peptone. In the latter case the pus was introduced by means of needles into the mass, which was then kept at the temperature of the room during three to five days. After that time, the puncture made by the needles assumed the appearance of white streaks, around which the gelatine liquified gradually and took an orange color. After a few days more, the mass gave out a smell like sour paste, and the microscope revealed the presence of large numbers of micrococci, having the same appearance as those found in the pus. A small quantity of the mass was mixed with sterilized water and injected into the peritoneal cavity of some animals; they died in a very short of acute peritonitis. The same fluid injected into the jugular vein caused acute septicæmia and death; but nothing abnormal was found in the bones in either case. Dr. Becker then injected a small quantity of the same fluid into the jugular vein of fifteen rabbits, after having, some days before, fractured or bruised the bones of one of their hind legs. On the day after the injection, weakness and loss of appetite were noticed; but after a short time the symptoms passed away, and the animals seemed to have recovered. At

the end of the first week, however, a swelling formed at the seat of the bruise or fracture, the animals lost flesh, and died after a few days. On dissection, large abscesses were found around and in the bones, and in several cases metastatic abscesses had formed in the lungs and kidneys. Numerous colonies of micrococci were discovered in the blood and pus of the animals upon which the experiments were made.—*Brit. Med. Jour.*

Marriage and Mitral Stenosis.—In a recent clinical lecture at *la Charité*, Dr. Landouzy stated that the mitral orifice is anatomically narrower in women. On the other hand, the hyperalkalinity of their blood leads to sclerosis. These conditions explain the frequency of mitral stenosis in women. Nevertheless, as long as the left auricle, says the *Journal de Médécine*, remains in good condition, the primary lesion makes but little progress; but when the great, vital test of pregnancy comes, there is danger.

Porak's statistics show that in gravido-cardiac disorders, as they are called, more than two-thirds of the cases are those of mitral stenosis, mitral insufficiency, or the two combined. Obstetricians are agreed in advertising that a woman suffering with mitral disease, especially mitral stenosis, should not marry; or, being married, should not have a child; or, having given birth, she should not nurse. A woman with mitral disease having been married, and becoming a widow without having borne a child, is in a most favorable condition if she remains content with widowhood. So, too, religious celibates who preserve their continence may have mitral stenosis, and live to the age of grandmothers.

Landouzy mentions the case of a young girl, who had been in the hospital under his care, and whom he had advised not to marry, but who disregarded his advice, married, became pregnant, and, after a miscarriage, died suddenly in an attack of asystole.

Of course, in cardiac disease, it is well to discourage marriage, but, in regard to such action, the old fable of Cupid being blind has countless illustrations, and at the bridal altar these

very maidens, like other brides, deck themselves with orange flowers, the very symbol of fecundity—whether they knew this or not—when they ought not to have a single pregnancy. But, when married, they are advised not to have children. How many women can control this matter? To avoid reproduction is very easy to advise, very difficult to do. Possibly it might be well to counsel these cardiopathics to prepare for marriage by first undergoing Battey's operation. But when the wife is not sterilized in advance, a similar proposition might be made to the husband, and in the day when our gentle sisters become professors of diseases of the male sexual organs, possibly normal orchidectomy may occupy as important a place in the surgical therapeutics of men as normal ovariotomy now does in diseases of women.

However, we are not sanguine that either plan of treatment for the prevention of pregnancy will be adopted; but we are inclined to think that germicide solutions may continue to be in demand by cardiopathic wives.—*Medical News.*

Traumatic Aneurism of the Vertebral Artery.—In the *Archives of Medicine*, for April, 1884, may be found the report of a case of traumatic aneurism of the right vertebral artery high up in the neck, which is interesting not only on account of the rarity of the lesion, but from the fact that Dr. R. F. Weir succeeded in effecting a cure by digital compression over the lower and anterior edge of the sac, in seven hours.

Dr. Weir tabulates eight similar cases, in which the error was committed of ligating the carotid artery. All proved fatal. He also refers to the case of Möbres, cured by the application of cold after pressure on the exposed external carotid had produced no effect on the tumor, and to that of Kocher, cured by graduated compresses of carbolized gauze acting on a pledget of lint, dipped in perchloride of iron, and crowded into the space between the transverse processes of the fifth and sixth cervical vertebræ. Hence, in the two cases in which the diagnosis was made, digital compression and direct compression have proved successful.

The great difficulty is in arriving at a correct diagnosis, which Dr. Weir says, may be done by "carefully considering the effect of pressure on the carotid, not only above, but also on a line with the transverse process of the sixth cervical vertebra, or rather over the anterior or so-called carotid tubercle. Compression above this point affects, as a rule, the carotid artery only; over and below the transverse process compression will not only occlude the carotid but also the vertebral artery, which runs to its outer side. It must be remembered, however, that the vertebral, instead of entering the foramen in the transverse process of the sixth cervical vertebra, its upward course sometimes remains exposed until it enters a foramen. To meet such possibilities, it has been suggested to isolate the carotid according to Rouge's plan, which is, with the sterno-mastoid relaxed, to grasp the muscle with the finger and thumb and to pinch the carotid between them. It is necessary also to keep in mind, in trying to effect vertebral compression, that the carotid tubercle is, according to Chassaignac, always from two to three inches above the clavicle. A traumatic aneurism whose pulsations are unaffected by compression of the carotid applied as above detailed, will be found to contain the vertebral artery."

In the treatment, ice and compression by bandages or the fingers having failed, the sac should be opened, the finger applied to the wounded artery until the clots are cleared away, and firm antiseptic plugging be resorted to, as was successfully done by Kocher in a case of aneurism, and by Kuester in two samples of wound of the artery.—*Medical News.*

Rupture of the Urinary Bladder.—Dr. B. Beck, General and Corpsarzt of the Fourteenth Armée Corps of the German army, has observed twenty-five cases of traumatic rupture of the bladder, and in the *Deutsche Zeit. f. Chirurgie*, xix, 4, 5, he reports two cases at length, and adds the following conclusions:—

1. That simple rupture of the bladder may be caused by direct or indirect violence—falls on the feet or the lower end of the trunk—and that the momentary position and attitude of the

body contributes in determining the situation, form and extent of such rupture. The bladder will always give way at its weakest part, the anterior or posterior wall, the point being determined by the direction in which the contents of the bladder are pressed by the outside force.

2. The only characteristic symptoms are those furnished by the wounded bladder itself, and these are: violent, frequently-returning attempts to urinate; inability to pass water spontaneously; flow of a small quantity of bloody urine on passing the catheter; strong contraction of the bladder, whereby its capacity is diminished; free movability of the catheter, after which the small emptied space speedily fills up with some urine, which sets up renewed straining. If bloody urine escapes, the diagnosis may be made of extra-peritoneal rupture, as it is only rupture of the anterior wall in the vicinity of blood-vessels that give rise to hemorrhages. Œdema of the external genitals, caused by disturbances of circulation, supports the diagnosis of extra-peritoneal rupture.

3. The fatal termination in cases of simple rupture of the bladder is not a consequence of peritonitis, but of intoxication by resorption of decomposed urine.

3. Internal medicines are insufficient. The first requirement is the introduction of a permanent catheter under strict antiseptic precautions.

As the urine that is poured out into the abdominal cavity is the greatest source of danger to the organism, the treatment in intra-peritoneal rupture should not be expectant. At the onset, or increase of local symptoms, if the general condition be gravely affected—and this will be seen in the course of a few hours—the following is the only mode of procedure calculated to save life: Laparotomy, removal of the urine poured out into the abdominal cavity, thorough disinfection, and, finally, closure of the bladder wound by suture. In extra-peritoneal rupture, when the urine has permeated the extra-peritoneal connective tissue, an expectant plan of treatment is allowable so long as changes at the centre of infiltration do not point to the necessity for surgical interference. The main point in the treatment is the

employment of a retaining catheter, with occasional cautious washing out of the bladder with some antiseptic fluid, in order that no fluids capable of becoming disorganized may be allowed to remain, to the jeopardy of the patient.—*Medical Press.*

Etherization by the Rectum.—Dr. A. Post reported three cases at the Boston City Hospital. The *Boston Med. & Surg. Journal* of April 17th had a short account of etherization by the rectum as done at Lyons. Its administration in that manner has been tried at the City Hospital since that publication. The ether has been given from a small bottle with a perforated cork, to which is attached a rubber tube, to the other end of which is fastened a catheter. The bottle of ether is placed in a vessel of warm water, and the catheter passed into the rectum. The ether is seen to boil in the bottle, and its vapor is conveyed through the tube into the bowel. The hot water used was drawn frem the hot-water pipes, and was so hot as to be uncomfortable to the hands. The first case was a patient of Dr. Homans, a man with cellulitis of the arm, who had been vomiting before etherization. After the tube was introduced he first complained of the taste of ether in the mouth. It was then noticeable to the bystanders in his breath. His pulse grew rapid, the pupils dilated, he partially stiffened out, put his hand to his mouth, vomited, and anæsthesia was complete at the end of thirteen and a half minutes. The ether was discontinued almost as soon as he was insensible, but the anæsthesia continued for nearly thirty minutes, probably not so complete as to allow surgical interference without shrinking during all that time, but so complete that he lay without motion. During the afternoon he had two or three loose discharges, mostly gas, for which he received a starch and opium enema, and which soon ceased.

The second case was a woman of large size, who had eaten a hearty breakfast before coming to the hospital. She took an ounce and three-quarters ot ether, and was insensible for thirty-four minutes. During the etherization the ether was administered evidently faster than absorption took place, as her abdomen became sufficiently distended to embarrass respiration; but a

little pressure on the abdominal walls caused the gas to issue from both ends of the abdominal tube, and all difficulty ceased. On recovering, this woman vomited perhaps an ounce of thin, yellowish fluid. Within an hour, had a natural movement of the bowels, and afterwards two slight loose operations, one of which was tinged with blood.

The third case was in every way a most favorable one except in length of time required to produce insensibility. The ether was given more slowly to avoid the distension of the bowels that had occurred in the previous case. A little less than two ounces was given, and etherization was complete in fifteen minutes. The stage of excitement was marked by a laugh and one or two comical remarks, but no struggle. Insensibility continued nearly 30 minutes, and no unpleasant symptoms occurred during recovery. This patient was operated on for piles, and her rectum was packed with sponges to provide against hemorrhage. Slight meteorism occurred, but no more than might well follow the closure of the anus. The sponges were removed after a few hours, but no diarrhœa showed itself.

So far as it is possible to draw conclusions from present experience, etherization by the rectum differs from inhalation principally by the absence, or rather the diminution, of the stage of excitement. If vomiting occurs during the etherization, it does not interrupt the administration of the anæsthetic. The unpleasant after effects seem less marked. Vomiting, if it occurs at all, is slight. The secretion of mucus, which so frequently fills the mouth and air passages, has not occurred so far. The spasm of the glottis which sometimes occurs at the commencement of inhalation, and which is the result apparently of the local effects of ether vapor, is not to be expected by this method. The feeling of suffocation which is so common when ether is given by inhalation, and which is the cause of most or at least a large number of the struggles which patients sometimes indulge in, is wanting. Of course the constitutional effects of ether, however given, are the same. The use of a much smaller quantity is sufficient to induce anæsthesia when given by the rectum, where all is absorbed, than when given by inhalation; at the same time

the effect is slower in most cases. After complete anæsthesia is reached it is apt to grow more profound after the supply of ether has been removed—so that its administration should cease when once the patient is asleep. The effect of ether upon different individuals varies very widely. It cannot be supposed that no patient will ever struggle if etherized by the rectum. Of course the man who makes a row whenever he is drunk will probably show his ugly disposition when ether is the cause of his excitement, but so far the excitement shown has been very small. The disagreeable effects seem to consist in the possibility of blowing up the rectum. Evidently the power of absorption differs in different individuals; probably the rate at which the vapor is poured into the rectum differs, as it ought to do, where the heat applied is indefinite and variable. It is necessary to watch the abdomen somewhat to see that it does not become ballooned. An irritation of the rectum is set up in some cases which, perhaps, corresponds to occasional effects on the air passages when the ether is inhaled, but nothing so far has transpired to cause alarm or anything more than a temporary inconvenience.—*Boston Med. & Surg. Journal.*

The Aryan Views of Doctors One Thousand Years Before Christ.—The Aryans were a remarkable race. Their views of their doctors are commendable even now. Billings gives some of these views, from which we quote. Susruta advises medical students, "That they must utterly abstain from love and from hate, from anger and laziness, and from greed for gain. They must pay consideration to their external appearances, and have care that their clothing is appropriate and cleanly. They must be servants to the truth. They must show the same respect to the Brahmins, to their treachers in medicine, to their friends, and to all who turn to them for help. The doctor must wear his hair short; his nails must be clean and closely cut; he must never leave his house except with his cane or sun-shade; and above all, he must avoid any undue intimacy with women. He must be handsome, well-built, amiable, earnest, but without self-conceit, friendly, and full of spirit; his speech must be soft, yet encour-

aging, as that of a friend; his heart must be pure and honorable; he must be a patron of cleverness and sagacity, and must love his patients better than relations, friends or parents. One may have a fear of a brother, a mother, or a friend, but never of his doctor." Besides the theoretical instruction by lectures and books, the student was trained practically by visiting patients, witnessing operations, assisting in the same, and practicing upon models. Before he could begin the practice of medicine, each student was required to obtain the consent of the ruler having charge of the practice of medicine. The doctor among the Aryans practiced by the authority of the state. Susruta says: "Not seldom, through the carelessness of the ruler, unsuitable doctors were admitted to practice. Such men flatter the friends of the sick, are very attentive, take less pay, are bold-faced, and never attribute the poor results of their practice to their own ignorance. The educated practitioner must flee the company of such men as a thicket full of ravenous animals. The reward of the practitioner must be ordered according to the means of his patients. It is dishonorable to demand pay of Brahmins, relations, friends and the unfortunate." Thus it seems that doctors of three thousand years ago among the Aryans, had a government regulation of their practice. It also seems that they had an ethical code far more exacting than that of the American Medical Association. With reference to irregular practitioners, they were to flee from them as from the wild beasts of the jungles. It is questionable whether the ethics of to-day furnish truer doctors in the best sense of the term, than were found in those ages. The difference between then and now consists mainly in the amount of knowledge that he has since accumulated. As to the ways of so using this as to best serve the race and the doctors themselves, the same principles of action and deportment hold good.—*Det. Lancet.*

Delivery Prevented by an Enlarged Fetal Spleen.—Surgeon-General C. R. Francis, of the British Army, reports in the *Med. Press and Circular* a very singular case which occurred in the practice of Dr. Webber, of Dinagepore, India: A well-formed native female, aged twenty,

was taken in labor with her first child, and attended by a native midwife. The labor had continued for several hours, when the civil surgeon was called, his services being desired owing to the cessation of all pains after the delivery of the head. The child was dead, but he corrected the position with facility, bringing the shoulders down and hooked down the arms with his fingers. In this position traction was practiced for two hours without any advance. At this time the head became detached. The woman was then placed under chloroform and podalic version performed, but still without effecting delivery. It was decided to open up the child's abdomen, the distension of which was an obstacle to delivery. A guarded scalpel was introduced, and, after the opening was made, an enormous and hard tumor was detected, which required to be broken up before it could be removed. The delivery was then easily accomplished, and it was then discovered that the tumor was an enormously enlarged spleen. The placenta came away in eight hours without flooding, and the woman made a complete though slow recovery.—*Maryland Medical Journal.*

The Tercentenary of Edinburgh University.—At the students' reception of the University guests, which was, perhaps, the crowning event of the festival week, Professor Virchow of Berlin made the following speech :—

"I should have wished to speak to you in your own language, but as I only received the invitation to this meeting on arriving in London, it was impossible for me to prepare a good address; therefore, I beg to be excused if I make a modest German speech." He then proceeded with his speech in German, of which the following is a translation: "In considering what to say that might be of interest to a group of students, I remembered that I would be speaking in this hall, not only to Scotland, but to England, Ireland, the Colonies, and the whole English-speaking world. I knew that great subjects were discussed in your University, in the wide range of which the teachings of this school were largely in accordance with my own. Among the matters which have a common interest for us, I am in such cordial sympathy with you that there is only one topic on which there may

seem to have been some disturbance in the happy relation which subsists between us. On that matter, therefore, you will allow me now to speak to you. I refer to the position which I am supposed to have taken up towards the teachings of Darwin. The opinions which I have expressed have, in some English publications, been much misunderstood. I never was hostile to Darwin, and never have said that Darwinism was a scientific impossibility. But at that time, when I pronounced my opinion on Darwinism at the Association of German Naturalists at Munich, I was convinced, and still am, that the development which it had taken in Germany was extreme and arbitrary. Allow me to state to you the reasons on which I founded my opinion. First, Darwinism was interpreted in Germany as including the question of the first origin in life, not merely its manner of propagation. Whoever investigates the subject of development comes upon the question of the creation of life. This was not a new question. It is the old *generatio equivoca*, or *epigenesis*. Does life arise from a peculiar arrangement of inorganic atoms under certain conditions? We can imagine oxygen, hydrogen, carbon and nitrogen coming together to form albumen, and that out of the albumen there was produced a living cell. All this is possible; but the highest possibility is only a speculation, and cannot be admitted as the basis of a doctrine. In science it is not hypotheses that decide, but facts; we arrive at truth only by investigation and experiment. I need not say that this demand of science for proof, instead of speculation, was long ago made in England. Ever since the time of Bacon it has had a home amongst you. We may concede that *generatio equivoca* is a logical possibility. But it is important for you students always to bear in mind the great distinctions between the construction of logical possibilities and their application in practical life. If you try to shape your conduct simply according to logical possibilities, you will often find yourself coming into violent conflict with the stern facts of existence. Let me give you an illustration. In recent times the fact of the presence of minute organisms giving rise to important processes has been recognized, not only in medicine, but in connection with agriculture and various in-

dustries. It was of the utmost importance to determine whether these organisms were originated *de novo* in the decomposing bodies, or were produced by similar pre-existing organisms, and introduced from without. A century ago it was possible to admit the spontaneous generation of micro-organisms. But M. Pasteur has demonstrated, by means of direct experiment, that, in spite of all logical possibility, all known micro-organisms found in decaying matter are derived from similar ancestors. No man would now be justified in practical life in acting on the possibility of a *generatio equivoca* of micro-organisms. A physician who finds himself in presence of infectious disease among his patients, or an agriculturist whose crops are blighted, or a man engaged in the production of alcohol or sugar by fermentation, must set himself to discover what brings about the changes with which he has to deal; he must see that organisms are there which have been imported from without, and must then inquire whence they have been derived. The physician who has to combat an epidemic dare not act as if the germ were spontaneously produced in any patient. Such is the difference between logical possibilities and the practical work of daily life. Every teacher of science must lead his students to suppose that each living being that he meets must have had a father and mother, or, at least, one or other of them; and every scientific conclusion maintains that one generation is legitimately descended from another precisely similar. That was one consideration that led me to warn my fellow-countrymen against developing a system out of logical possibilities. At the very time when we were getting free from the chains of former dogmas, we seemed to be in danger of forging new ones for ourselves. The second question concerning Darwinism had regard to the descent of man, whether from apes or other vertebrate animals. Was there anywhere a pro-anthropos? In regard to this question, I thought that the existence of such a precursor of man was a logical possibility, perhaps a probability. Only I found, to begin with, that it was a purely speculative question: not one raised by any observed phenomenon. No pro-anthropos had ever been discovered; not even a fragment of him. I had myself long been specially occupied in making prehistoric in-

vestigation to get near the primitive man. When I began these studies, twenty years ago, there was a general disposition to arrive at this discovery. Everybody who found a skull in a cave, or a bone in the fissure of a rock, thought he had got a bit of him. I wish you specially to notice that the smaller the fragment of skull, the easier it was to make out to be the skull of the pro-anthropos. It was never thought of where an entire skull was in hand. When the upper part of the cranium alone—the calvarium without the face and the base, as in the case of the Neanderthal skull—was discovered, it was easy, by changing its horizontal position, by elevating either the anterior or posterior part, to give the impression that it had belonged either to a being of a superior or of an inferior race. You can make the experiment with any calvaria. If you make a series of diagrams of skulls, placing them over each other, you may make them appear similar or dissimilar, according as you choose one or another fixed point for bringing them into relation. I should like to impress upon you that every discovery of that kind should be received with caution and scrutiny. In my judgment, no skull hitherto discovered can be regarded as that of a predecessor of man. In the course of the last fifteen years, we have had opportunity to examine skulls of all the various races of mankind—even of the most savage tribes—and among them all no group has been observed differing in its essential characters from the general human type. Hence I must say that an anthropological teacher has not occasion to speak of a pro-anthropos except as a matter of speculation. But speculation in general is unprofitable. As Goethe says:

> "Ein Kerl der speculirt,
> Ist wie ein Thier auf oeder Heide,
> Vom boesen Geist umhergefuhrt."

("A speculating fellow is like a beast on a barren heath led about by the Evil Spirit.")

The day before I gave the address in Munich to which I have referred, Haeckel had gone so far as to propose to introduce into our schools a new system of religious instruction, based upon the doctrine of the *Descent of Man;* and I still think it necessary to guard against the danger of constructing systems of doctrine

out of possibilities, and making these the basis of general education. Lastly, I have to refer to the geological aspect of the question. This is the most important aspect of it as treated by Darwin himself; and here we must recognise that the most important advance has been made in consequence of his ideas in our understanding of the progressive development of organs in the different classes of animals. From the earliest period, the organisation of man has been regarded, and can only be regarded, as an animal organisation; and, therefore, from a zoological point of view, the body of a man must be regarded as belonging to the animal kingdom. That I do not wish to deny. This day ten years ago, Liebig died. I recall his memory at this moment to repeat one of his memorable sayings, "Natural science is modest." He meant that science should be confined within the limits of observation. Every man who goes beyond that sphere becomes a transcendentalist, and transcendentalism has always been dangerous to science."—*Brit. Med. Jour.*, May 3.

Downward and Backward Dislocation of the Acromial End of the Clavicle.—The *New York Medical Record* says: Dr. Cassius D. Wescott, of Chicago, Ill., sends us a report of the following very rare case: "Mrs. K——, aged twenty-six years, while going down stairs made a mistep and fell three steps, striking against the baluster in such a way as to drive the acromion process of the scapula *over* the end of the clavicle. I saw her twenty-four hours after the accident. There was little swelling and no pain, except upon motion of the arm; notable absence of the usual prominence of the clavicle in its outer half, but by burying my fingers deep in the neck, I could outline the bone to its extremity, as it passed beneath the acromion, and demonstrate the absence of fracture. With the assistance of my friend Dr. Luce, the patient was etherized and I reduced the dislocation by putting my knee between the shoulders and drawing them forcibly backward. Some difficulty was experienced in maintaining the reduction, but patient recovered without 'impairment of function' and with no visible deformity. Prof. Edmond Andrews in the 'International Encyclopædia of Surgery,' says that only five similar cases have been reported."

CANADA

Medical and Surgical Journal.

MONTREAL, MAY, 1884.

A CASE OF OPIUM-POISONING TREATED WITH ATROPINE.

Dr. Finlay recently reported a case of opium-poisoning before the Medical Society of London, where life was no doubt saved by the judicious use of atropine. The patient, a man aged 36, swallowed, 20 minutes before his admission into the Middlesex Hospital, a quantity of tincture of opium and the compound tincture of camphor, equal to seventeen grains of dry opium. Before the stomach-pump could be used his respiration ceased. The employment of artificial respiration soon restored him. The contents of the stomach were then removed. Failure of respiration occurred a second time, but was again relieved by the employment of artificial respiration. In spite, however, of coffee, stimulants and compulsory exertion, the respirations became gradually less and less in number, until they were reduced to two in the minute. The $\frac{1}{60}$ of a grain of atropine was given hypodermically, and repeated in half an hour. The respirations, a few minutes later, were found to be fully doubled on the average, although they continued irregular for some time. The pupils were soon noticed to be less contracted. In about three hours the respirations had reached ten per minute. The patient gradually recovered.

This case well illustrates the physiological antagonism which exists between opium and atropine, especially on the respiratory centre in the medulla. Dr. Finlay's patient was evidently dying from paralysis of his respiratory centre, and there seems to be no doubt whatever but that his life was saved by atropine, and that the atropine acted by stimulating the respiratory centre.

In treating a case of opium-poisoning with atropine, it is perfectly safe to give the latter in doses of up to the one-fourth of a grain, but higher than this it is not quite safe to go. It has, however, been given, and only with benefit, in doses of one grain. The doses given by Dr. Finlay were very small, and, considering the urgent symptoms present, too small. No harm could possibly have arisen by using it in doses of at least the $\frac{1}{10}$ of a grain.

PROVINCIAL MEDICAL BOARD.

The semi-annual meeting of the Provincial Medical Board was held in this city on the 14th inst. A detail of the proceedings will be given in our next number. The accusations already made by Dr. Lachapelle against Victoria Medical College of having been guilty of grave irregularities were formally presented. A long discussion ensued, in which a good deal of warmth was displayed on both sides. It was finally resolved to refer the matter to a committee, to be composed of the four members of the Victoria College already investigating the case together with the members of the Board resident in the city and district of Montreal, this committee to report at the next semi-annual meeting in September. Dr. Geo. Ross again referred to the hasty manner in which the license examinations were conducted, and urged the Board to immediately consider the question of making suitable arrangements for the holding of these examinations prior to the general meeting. As it is now, these examinations possess neither the confidence nor the respect of the public.

MONTREAL GENERAL HOSPITAL.—At the usual quarterly meeting of this institution, held on the 14th inst., the president asked for an expression of opinion from the governors present on the advisability of proceeding with the erection of a new building, the present structure being considered inadequate for the requirements of the city. He stated that he had in his possession certain plans drawn up by an English architect, but which he was not at liberty to produce at present. Many thought that an architect accustomed to this climate, or acquainted with

its peculiarities, would be in a better position to devise a suitable building than one who had never even visited this side of the Atlantic, as is the case with the gentleman whose plans are in the possession of the president. The whole matter was therefore referred back to the Committee of Management, to report on at the quarterly meeting in November. It is quite possible that the new building will not be proceeded with for some time, or at least until a sufficient fund is raised, say half a million dollars, to meet the increased expenses.

—The following letter appears in the *Canadian Practitioner*, signed by six well-known physicians in Toronto :—

To the Editors of the Canadian Practitioner :

Will you kindly allow us space in your journal to make an explanation with regard to our names having appeared as subscribers to a work on "Domestic Medicine." The book was left at our residences under the pretext, in nearly every case, for examination, and a slip was presented for signature. The person who left it, in each case, said he desired the signature merely to show that the book had been received, and for no other purpose. Not wishing to act discourteously, we signed the slip, which was a simple receipt for the work, and the agent has no authority to use in his advertisement our names as subscribers for the "Practical Home Physician."

Several of the leading men in this city have signed *receipts* for this same book, and have been informed that their signatures thus obtained have been used to represent them as signifying approval of the book. If this has been done, a great injury has been inflicted upon them, and the case affords another warning to medical men to be extremely cautious in signing any printed paper relative to any book, preparation, instrument, or what-not. The "Practical Home Physician" is not, in our opinion, in any way a proper or suitable book to be circulated in private families, and we should be sorry to be made to suggest anything to the contrary.

—Some time ago, *L'Union Medicale* published an article headed "*Fiat Lux*," in which it was stated that certain students had received a private examination, and obtained certificates therefor from one of our local Universities. Circumstances pointed to Bishop's College as the one accused. To clear themselves from this insinuation, they took criminal action for libel against the editors of that journal. The grand jury threw out

the indictment, and the editors, in their turn, sued Dr. F. W. Campbell (Dean) and other members of the Faculty for damages. This case has recently been decided, Judge Johnson holding that no case for damages had been shown.

CARBOLIC ACID IN TYPHOID FEVER.—With many physicians it has been the habit to prescribe carbolic acid in typhoid fever. Especially in France is this practice common. Whether it does any good or not, has not been determined, but that its indiscriminate use is occasionally followed by untoward effects is highly probable. Robin, of Paris, enters a strong protest against its use, on the ground that its presence in the blood robs the tissues of sulphuric acid and potassium. Carbolic acid combines with the sulphates in the blood, and in its elimination the tissues are in consequence robbed, not only of their sulphuric acid, but also of their potassium and sodium, especially the former; and when we remember that a typhoid patient looses more of these compounds than a healthy person, we have sufficient reason to make us slow in recommending carbolic acid in this disease.

HYPODERMIC INJECTIONS OF CHLOROFORM.—M. Bouchard has made a series of experiments on rabbits and dogs, in order to determine the effect of subcutaneous injections of chloroform. A cubic centimetre of chloroform injected under the skin had no apparent effect on the animals until 24 or 36 hours had elapsed, when violent albuminuria declared itself, and death quickly ensued. Three-fourths of a cubic centimetre determines death; one-fourth results in one-half of the animals under experiment being attacked by albuminuria; one-fifth does not induce albuminuria. M. Bouchard supposes albuminuria thus produced to be due to chloroform poisoning, and that hypodermic injections of chloroform should be practised on patients with the greatest prudence. The cause of the death of the animals consequent on albuminuria remains unexplained.

CORROSIVE SUBLIMATE POISONING FROM INTRA-UTERINE IRRIGATION.—As most of our readers know, corrosive sublimate, in solutions of from one to a thousand, fifteen hundred, and two thousand, is coming very much into use as a substitute for car-

bolized water as a lotion for irrigating the vagina and uterine cavity in puerperal cases. In view of this fact, it is of the utmost consequence that it should be generally known that it is a remedy by no means free from danger. Professor Stedtfedt of Copenhagen has recently reported a fatal case after intra-uterine irrigation with a solution of one part in fifteen hundred. The symptoms were slight collapse during the injection, and subsequently diarrhæa, vomiting, and suppression of urine, which quickly led to death. Hoffmeier reports another fatal case at Schrœder's clinic in Berlin. The symptoms were similar to those in Stedtfeldt's case. Mercury was found in the tissues. A third case is reported in the *Centralblatt für Gyn.*, April 26, 1884, by Mäurer of Coblenz. This latter recovered after most alarming symptoms. These were a cutaneous eruption (affecting also the vagina) of red points and erythematous patches, high temperature, rapid pulse, and fetid diarrhœa.

THE TREATMENT OF ACNE.—Dr. Piffard, the well-known American dermatologist, considers that, in the treatment of acne, internal measures are more important than external applications. For the common form (*acne vulgaris*), he says that the sulphide of calcium, given in small doses, is the most trustworthy agent that we possess. Next in usefulness he ranks the bromide of arsenic, which should be given in doses of from the $\frac{1}{100}$ to the $\frac{1}{60}$ of a grain. It is best administered in alcoholic solution, well diluted. For a local application in acute cases, he recommends an ointment of belladonna; and in subacute and chronic, green soap or some mercurial ointment.

—There is a bill at present before the United States Congress entitled "An Act to regulate the carriage of passengers by sea," which provides for a regularly *licensed surgeon* on every steamship or vessel having more than fifty steerage passengers on board. Where the number of passengers exceeds six hundred, an assistant surgeon will be required. Every passenger ship must also be provided with two compartments, to be used exclusively as hospitals.

Obituary.

THE LATE DR. DICKINSON.

With sincere regret we chronicle the death of James J. Dickinson, M.D., C.M. (McGill, 1846), of Cornwall, Ontario, which occurred suddenly on the evening of the first of May. Dr. Dickinson was the son of the late Dr. Noah Dickinson, a gentleman who, being one of the U.E. Loyalists, left the United States and settled in Cornwall as a practitioner of medicine toward the end of the last century.

The subject of our notice led a somewhat eventful career. Born in the year 1819, he was of an age capable to bear arms during the troublesome times of the Canadian rebellion. He was in the affair of the Windmill Point, near Prescott, Ont., on the 13th November, 1838, serving in the ranks of the 2nd Regiment of Stormont Militia. The following December he was gazetted Ensign in the 3rd Provisional Battalion, which force was afterwards merged into the 5th Battalion of Incorporated Militia, and Mr. Dickinson was appointed lieutenant. In this capacity he served until the regiment was disbanded. In 1842 he commenced the study of medicine, and graduated at McGill University, M.D., C.M., in May, 1846. During the year following, Canada was visited by what was termed *ship fever*, a severe form of typhus, due in a great measure to a large emigration, chiefly from Ireland. The emigrants were forced to leave their homes in consequence of the failure of the crops. Dr. Dickinson, with many others, heroically braved the danger, and went to Grosse-Isle, the quarantine station below Quebec, where temporary hospitals had been established by the Government for the relief and care of those who came to our shores to die. We could record the deaths of many of our own class-mates who, with our late friend, entered the same service. There were few of that little heroic band that escaped the disease, and many of them succumbed to it. The names of Fortin, Jacques, Pinet, Malhiot, Paradis, Allan, Keefer, and others occur to us, and although nearly forty years have passed since some of them left their bones to whiten on the Grosse-Isle shore, still is their

memory green, and this incident of one of the number passing away, in peacefulness and honor, recalls to our memory many of the circumstances of our youth and early manhood. These, indeed, were busy times, and no greater proof of the heroism and devotion of the members of the medical profession can be offered than when a little band of men, like a forlorn hope, stood in the breach to wait upon and serve those afflicted with plague and pestilence, even at the risk of their own lives.

Dr. Dickinson, in August, 1847, came to Montreal from Grosse-Isle with typhus fever, and went through that disease in this city, after which he returned to his duties at the Island, where he remained until the close of the season. He subsequently settled in Cornwall, his native town, and practiced his profession throughout life. In 1850 he married Mary, daughter of the late Rev. Salter J. Mountain, M.A., of Cain's College, Cambridge. Mrs. Dickinson survives, as also three sons and six daughters. Dr. Dickinson was an excellent surgeon, a man full of resources, very practical, and as a physician, there were none in the country round his superior, and few his equal. Many will miss him, now that he is gone, for he was kind, courteous, and a strict observer of medical ethics. He was a general favorite, and as a practitioner, was consulted far and wide by his *confrères* on both sides of the St. Lawrence river. His was an active and valuable life, and like many another, worked to the very last with a full interest in the service of his calling, making monetary reward a secondary consideration.

G. E. F.

PROFESSOR S. D. GROSS.

The celebrated Professor Gross, of Philadelphia, died on the 6th inst., after a short illness. We copy the following obituary notice from the *New York Medical Journal*:—

Samuel D. Gross, M.D., LL.D., D.C.L,, emeritus professor of the institutes and practice of surgery in the Jefferson Medical College, was born near Easton, Pa., July 8, 1805. After a high-school education, he studied medicine as a pupil of the late Dr. George McClellan, and received the degree in medicine

from the Jefferson Medical College in 1828. He began practice in Philadelphia, but returned to Easton in 1830. In 1833 he removed to Cincinnati, having been made demonstrator of anatomy in the Medical College of Ohio. In 1835 he became professor of pathological anatomy in the medical department of the Cincinnati College. During his stay in Cincinnati he earned a wide reputation as a surgeon and as a contributor to the advancement of medicine. In 1839 he was made professor of surgery in the University of Louisville, where his fame soon became national. In 1850 he came to New York, having been appointed to the chair of surgery in the medical department of the University of the City of New York, as the successor of Dr. Valentine Mott. He served but one season in this capacity, however, and returned to Louisville in 1851. In 1856 he was chosen professor of surgery in the Jefferson Medical College, succeeding Dr. Mütter, and he remained in Philadelphia thereafter.

During the early part of his career as a teacher, Dr. Gross was chiefly known to the profession throughout the country as the author of a systematic treatise on pathological anatomy which was for many years the standard text-book in America. In 1859 the first edition of his "System of Surgery," a colossal and monumental work, was published. This book at once took a prominent place in the surgical literature of the world, and, perhaps, more than any other single work ever issued from the American press, served to disclose the achievements of the American profession to their colleagues in foreign countries. Ever since it appeared it has been everywhere considered as among the best treatises on the subject. Dr. Gross was the author of several other works, all of which bore evidence of excellence, and at one time he was the editor of the "North American Medico-Chirurgical Review." He was the first president of the Philadelphia Pathological Society, of which he was one of the founders, and at different times he was president of the American Medical Association, of the Pennsylvania State Medical Society, of the International Medical Congress, and of the American Surgical Association. He received distinguished

honors from a number of foreign universities, including the degree of D.C.L. from Oxford and that of LL.D. from Cambridge and Edinburgh, the degree from the latter university having been conferred upon him *in absentia* at the tercentenary festival.

In addition to these formal honors, Dr. Gross was held in heartfelt admiration and esteem by the great mass of the profession in the United States, of which there could be no more touching mark than the action of the American Medical Association at the meeting held last week in Washington. Few men ever lived who bore greater sway over the medical professon than Dr. Gross has borne for many years past, and his influence was due to no art, but to a simple power of a long course of devotion to the best interests of those who delighted to do him honor. The world is better for his having lived, and no one will read the announcement of his death without a feeling of sadness. There is something touching in the fact that Dr. Gross and Dr. Willard Parker, who were closely associated in their early life, have paid the debt of nature within a few days of each other.

Personal.

Dr. Roddick has returned to the city and resumed practice.

Dr. James Bell, late Medical Superintendent of the Montreal General Hospital, has commenced private practice in Montreal. We wish the doctor every success.

Dr. James Gray succeeds Dr. Bell as Medical Superintendent of the Montreal General Hospital. His term of office expires in May next.

Dr. William Stephen, who has been absent for some months in London and Vienna, returned to his old quarters a few days ago.

Dr. Buller joined the benedicts on the 16th ult., and returned to the city a few days since after an extended bridal tour. He will please accept our heartiest congratulations.

Drs. Osler and J. B. Howard have reached Berlin, where they purpose spending two or three months in the pathological laboratories and lecture-rooms of that great medical centre.

Dr. John Gardner, brother of our esteemed Professor of Gynecology, intends hanging out his shingle in Point St. Charles. We predict for him a very prosperous future.

Drs. Fergusson (medallist, 1884), Johnson and Graham have been elected to the resident positions in the Hospital made vacant by the resignations of Drs. Gardner, Gray and Henry.

Dr. James C. Irvine (McGill, '66), is whiling away a few months of leisure as surgeon of the "Circassian." The doctor spent several years on the west coast of Africa, where he appears to have practised his profession most successfully.

We had the pleasure of meeting our old and esteemed friend Dr. Wickwire of Halifax the other day, when passing through that city. We hope to see him in Montreal at the meeting of the Canada Medical Association in August.

Medical Items.

—Twenty ladies graduated at the Woman's Medical College of Philadelphia at the last commencement.

—The "Planet," edited by Dr. E. C. Nelson, of New York has been discontinued. It will be missed by those who enjoyed the piquant humour peculiar to it.

—Carbolic acid is the best disinfectant for phthisical sputum, according to the experiments of Drs. Schull and Fischer. A five per cent. solution will disinfect an equal amount of sputum.

—In 1866, carbolic acid first appears in the dispensary-books of King's College Hospital, in which year it cost £5 8*s*. Last year the Hospital paid £126 for this article alone. Notwithstanding this, however, the average drug expenditure has considerably diminished in that time, the adoption of antisepticism being thus an economical move in spite of the high price of carbolic acid.

—The late Prof. Gross of Philadelphia set a noble example in having ordered his body to be cremated. If every member of the medical profession who dies in the present year could be induced to make the same arrangements for the disposal of his remains, cremation would soon become fashionable.

—The American Medical Association held its annual meeting in Washington last week. Judging from the reports to hand, the session must have been a great success. The elder Gross was lying on his death bed at the time, and when asked if he had any word to send the Association said in a feeble voice, "Give them my love." A special committee, of which Dr. Billings is chairman, was formed to arrange for the meeting of the International Medical Congress in the United States three years hence. We notice with pleasure that our old esteemed friend, Dr. Botsford, of St. John, was present as delegate from the Canadian Medical Association, and was invited to a seat on the platform. He was accompanied by Dr. Steens, also of New Brunswick.

One Good Effect of Listerism.—Since the introduction of antisepsis into Germany and Austria, German surgeons no longer, it is said, wear mourning under their finger-nails.

Efficacy of Bichloride of Mercury in Ringworm.—In the February number of the *Journal of Cutaneous and Veneral Diseases*, Dr. R. W. Taylor recommends a solution of corrosive sublimate in the treatment of the various forms of ringworm. He found that the efficacy of the mercury was much enhanced by dissolving it in tincture of myrrh. The strength of the solution was four grains to the ounce. Eczema marginatum, and ringworm in general, were readily cured by thoroughly painting the affected parts with this parasiticide solution. It was applied twice daily. He believes that the tincture of the gum-resins make excellent vehicles for various agents in the treatment of skin diseases.

CANADA

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CYSTITIS.

A Lecture Delivered on May 17th, 1884, before the Summer Session Class in Gynæcology, McGill University.

By WILLIAM GARDNER, M.D.,

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Gentlemen,—The subject of the lecture for this morning is, if judged by its frequency and the amount of distress it causes the unfortunate sufferer, one of the most important that can engage our attention. You will meet with it in a great variety of circumstances, and unless you are forewarned, you may, perhaps, diagnose the disease when it is not actually present.

While in some respects the disease resembles cystitis in our own sex, it differs from it in many others. These differences refer mainly to the causation, as influenced by that important adjacent organ, the uterus, with its remarkable functions and the many diseases to which it is subject. This is neither the time nor the place to enter into a detailed consideration of cystitis in women. Those of you who may wish to pursue further the study of the subject, I refer to Skene's work on the "Diseases of the Female Bladder and Urethra," and Winckel's Treatise in Billroth's *Handbuch der Frauenkrankheiten*. I purpose, therefore, to consider it in some of its more practical aspects as it presents itself to the practitioner. It is divided into *acute* and *chronic*. It may affect each or all of the coats of the bladder, and so be of the *mucosa*, of the peritoneal investment, or of the muscu-

lar coat. But these are often steps in a general process, the disease beginning in the *mucosa* and extending to the other coats, and this is the most frequent order, or beginning in the serous coat, as an epicystitis or pericystitis, and extending inwards to the mucous coat, which is much rarer. The causes are many. Injuries from blows, falls, coitus, sudden displacement of the uterus, fracture of pelvic bones, pressure of the child's head during labor, over-distension of the organ after labor or under other circumstances, rough catheterization or frequently repeated gentle use of the catheter, introduction of foreign bodies as practised by masturbating and hysterical women, abnormal urine, and extension of inflammation from adjacent organs, as of gonorrhœal or simple vaginitis or vulvitis, or from the peritoneal surface. A little more extended consideration of some of these causes will be profitable. The pregnant, parturient, and recently-delivered woman, in whom the parts are in a condition of physiological activity and of increased vascularity, or have undergone contusion from pressure, or are paralyzed, and so liable to over-distension, is especially prone to cystitis. Hence the great frequency of the disease under such circumstances, and its unusual difficulty of cure. Of catheterization, it must be said that it is always a source of irritation, however gently performed. How much more-so must it be if done roughly, and if the necessity be frequent. But there is another source of danger in the use of unclean catheters. Winckel has said that the mucous membrane of the bladder is the most sensitive in the body, to sepsis. These facts convey to you self-evident and important cautions.

Abnormal urine is most important in its effects in causing inflammation of the mucous coat of the bladder. Probably, however, it is not so powerful if the mucous coat be healthy. Congestion, as from over-distension, furnishes a sufficient predisposition. Women frequently suffer from over-distension of the bladder in conditions other than puerperal. "The Relation which Faulty Closet Accommodation bears to the Diseases of Women" is the title of a lecture, on a somewhat unsavoury subject, by the eloquent Goodell of Philadelphia. For such reasons and others, women often delay emptying the bladder for a long

time after there is a safe amount of distension. Many cases of cystitis are thus set up in the sex. Now let us see how such a cause may act. Over-distension of the bladder means congestion. Over-distension leads to deficient power to expel the last drops of a urine which, from the congestion, contains mucus. The mucus decomposes. It sets up decomposition of the urea, and carbonate of ammonia is produced. This renders the urine alkaline, and therefore foreign and irritant to the coat of the bladder. Another result of alkaline urine is the precipitation of the earthy and triple phosphates, and so inflammation is set up.

The symptoms of cystitis are well marked. Frequent and painful micturition, accompanied with tenesmus of the bladder. The pain, at first local—pelvic and perineal—radiates to the navel or the breast and loins. The urine, at first pale, of low specific gravity, and acid, becomes alkaline and turbid from blood, mucus, pus and precipitation of phosphates. The disease is not always confined to the bladder. It may extend up the ureters to the kidneys, and so ureteritis, pyelitis, pyonephrosis and renal abscess result. In the bladder itself, a cystitis, at first merely catarrhal, may become ulcerative, or the inflammation may be diphtheritic or gangrenous.

The diagnosis is usually easy, but it cannot be made from the symptom of frequent and painful micturition. The urine must contain mucus, blood or pus. The conditions with which it may be confounded are irritation of the bladder from uterine displacement; irritation or inflammation, with cicatrization of the utero-sacral ligaments, other forms of pelvic peritonitis, fissure at the neck of the bladder, urethritis, and stone in the bladder. As regards most of these, it may be said that to be forewarned is to be forearmed.

The prognosis is much better than it would have been twenty years ago. In healthy subjects it is good. In the pregnant or lying-in woman, it is not so favorable. It is in such more apt to become chronic, and to leave the part weakened and sensitive. When ulceration is present, the outlook is by no means so favorable, although not absolutely bad. The tendency to hemorrhage, to extension to the peritoneum, to perforation, to extension to the kidney, to

blood-poisoning, constitute many avenues to a fatal result which sometimes comes to the patient when it is not expected.

The treatment, being suitable, ought to be early and prompt, to prevent the disease becoming chronic. When this stage has been reached, it will require the exercise of much of your own patience, as well as that of the sufferer. In the acute stages, keep her at rest in bed, keep the skin acting, and also the bowels, by the use of saline laxatives or mineral waters, aided, if necessary, by cold water enemata. Indigestion must be removed, and a free portal circulation maintained. An important indication is to render the urine as bland and unirritating as possible. A diet of large quantities of skim-milk, diluted, in cases where the urine is very acid, with some natural alkaline water, as Vichy or Apollinaris; but the supercarbonated potash water made by Chas. Gurd & Co. of this city, and the ærated water of the Caledonia saline spring, as charged by the same firm, are equal to any, and, of course, much cheaper than imported waters. Linseed tea and the decoction of triticum repens in large quantities act as diluents to the urine, and perhaps as something more, especially in the case of the latter. A good prescription in the early stages is a combination of citrate or bicarbonate of potash with infusion of buchu. From Sydney Ringer's prescription of drop-doses hourly of tinct. of cantharides I have had no good results, and cannot therefore recommend it. Leeches to the anterior vaginal wall, and poultices of linseed meal and tincture of opium to the hypogastrium, are often of undoubted value. To relieve the severe pain and distressing tenesmus, you will be obliged to give sedatives and narcotics, but I must caution you to withhold the most powerful of these, the opiates, as long as possible. They undoubtedly relieve pain, but they also derange digestion and act injuriously in other ways. By mouth, the Dover's powder is the least injurious. The rectal suppository is probably the most efficacious form for the administration of morphia or other remedies. Other remedies are, however, to be first tried. Camphor is useful. The bromide of potassium sometimes acts best. It must be given in full doses—20 grains every four hours. Skene speaks well of hydrobromic

acid. It may be given in doses of two to four fluidrachms of the dilute acid, well diluted with water. Marked alkalinity of the urine furnishes an indication not very easily met. The only acid useful for this purpose is the benzoic; the dose is 10 grains. A small dose, say 5 grains, of borax should be added to render the benzoic acid soluble. The combined dose may be given in infusion of buchu. In the later stages of this, as of other mucous inflammations, balsamic remedies sometimes do good. Balsam of Peru and of Copaiba, and oil of turpentine, are the most useful. In cases where there is markedly fœtid urine, salicylate of soda has been highly commended. But the time soon comes, in cases at all severe, at which local applications to the vesical mucous membrane must be used, if we are to do the best for our patients. The simple washing out of the bladder is often of the greatest value; but the method of this simple operation is of the utmost consequence. If done carefully, so that the coats of the bladder suffer no mechanical violence, much good may be effected; otherwise it may be most injurious. As a rule, the piston or bulb syringe must be avoided. Use, then, a fountain syringe. The most convenient form is a small-sized glass funnel, with two feet of rubber-tubing attached, the other end of the tubing being slipped over the open end of a No. 8 gum-elastic catheter. Violent contact of the coats of the bladder as it contracts with the end of the catheter is often most hurtful. To obviate this, the catheter must be made to barely enter the cavity. To attain this, especially when the patient or her attendant (as must often be the case) administers the injection, slip over the catheter a guard, which may be a piece of thin, flat wood or gutta-percha perforated, leaving only 2½ or 3 inches of the catheter from its point. The guard rests against the vulva and prevents the catheter penetrating more than is necessary to just enter the cavity. With such a simple cheap apparatus, which any one can prepare in a few minutes, every object may be attained in the majority of cases. Gravity is the injecting force. It is even, not jerky, and may be as gentle as desired, according to the height of the funnel. The patient being placed on her back, with the knees drawn up, the catheter is inserted,

and without removing it, the bladder may thus be thoroughly washed out, and the cleansing fluid having been allowed to flow out, the medicated solution is run in. To avoid irritation from over-distension, no more than, at most, two fluid ounces ought to be injected at once. This is a point on which Sir Henry Thompson is most emphatic in his instructions for injecting the male bladder. It is equally important in the female. Next, some instructions as to the solutions you are to use. For mere washing-out purposes, solutions of common salt or of potassium chlorate are best—3i to the pint. These solutions are less irritating than plain water. Carbolic acid, 1 to 60, is also valuable. Then there are various astringents which sometimes are beneficial. Such are acetate of lead, sulphate of zinc, and tannic acid, one or two grs. to the ounce. Of this class of remedies, I have reserved for last that which, in my opinion, is the most valuable—the nitrate of silver. You will find, by most writers, solutions of 1 to 2 grs. to the ounce recommended. This is far less valuable than a much stronger solution, 30 or 40 grains to the ounce, of which I have had some recent very satisfactory experience. Such a solution causes severe pain and vesical tenesmus for a few minutes, and it is well to be prepared with your hypodermic syringe when administering it, which usually must be at the patient's own home. Confinement to bed for a day after is advisable. I may here mention a case I recently saw. The symptoms were of several years' duration, and came on after confinement. During nearly a year I had tried a variety of astringents, with only slight benefit, but my attention was directed, during the winter, to the stronger solutions of silver nitrate by an article in the *Philadelphia Med. News*. I resolved to try the remedy. The results were most satisfactory. After two applications, the patient expressed herself as being better than for eight years. In this strength, the remedy ought not to be used oftener than once a week. Morphia has been injected to relieve severe pain. Solutions of 1 to 2 grs. to the ounce may be employed.

The value of rest, so well recognized in the treatment of surgical cases, and of medical cases, too, is no less in inflammations of the bladder than other inflammations. It is the difficulty of

attaining this which renders cystitis hard to cure. In some cases, especially when the urethra is not involved, this may be attained by placing a catheter in the bladder, and allowing it to remain there constantly, removing it twice daily only for the purpose of cleansing it. This is to be done by forcing a stream of carbolized water through it. When a catheter can be thus tolerated, it will be of great value. Some years ago Dr. John Goodman of Louisville, Kentucky, published a paper in the *American Journal of Obstetrics*, Vol. VII, page 413 (1874), in which he reported a series of cases in which the method proved most valuable. He used a short catheter with a bulbous extremity, which secures its retention within the bladder. The other end is provided with a flange, which prevents it slipping in. A piece of rubber tubing attached to the outer end conveys the urine to some convenient receptacle. I show you Skene's modification of the Goodman catheter. Another means of securing rest is by an operation which has been done rather frequently in recent years. I mean rapid dilatation of the urethra. I reported a case of severe chronic cystitis cured by this operation, in the CANADA MED. & SURG. JOURNAL for February, 1881. I had, however, a subsequent failure, but the case was a much worse one. At that time I did not know the value of the strong solutions of nitrate of silver, or probably I should not have done the operation, which has been followed in many cases by the deplorable result of permanent incontinence of urine.

Lastly, and, as I believe, the most valuable resource of all for securing complete rest of the bladder, an artificial vesico-vaginal fistula may be formed. This operation was first done by the late Dr. Willard Parker of New York for the purpose of drainage of the bladder, in a man. Dr. Emmet of New York justly claims priority in the performance of the operation for the cure of chronic cystitis in women. By it the bladder is placed completely at rest for the requisite length of time, and an opening afforded for the application of medicated fluids to the lining membrane. It is true that the patient becomes a sufferer from a distressing infirmity, but one involving much less suffering than the condition for which it was inflicted, and perfectly curable by sub-

sequent operation. If it be further remembered that it is the only mode of treatment which affords a chance of life to the sufferer from a disease which so often leads to death from extension to the kidney or otherwise, its justification must be complete.

REMARKS ON VARICOCELE AND ITS TREATMENT.

By T. G. RODDICK, M.D.,

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(*Read before the Medico-Chirurgical Society of Montreal, May 23rd*, 1884.)

The condition known as varicocele, or varix of the spermatic veins, is so familiar to you all, that it is unnecessary for me even to refer to its symptoms, causation, or diagnostic characteristics. It is usually regarded as a trifling affection, and one deserving of little attention. To this view, however, I am disposed to take exception, although, in so doing, I know I am at variance with some of the most eminent authorities in surgery. Thus, in those admirable clinical essays of his, Sir James Paget refers to varicocele as the disease of the hypochondriac, and hence unworthy of serious consideration. He admits, however, that it can be troublesome, from the sense of weight and aching which sometimes attends it. He ridicules the idea that it ever produces atrophy of the testicle. The writer of the article on Varicocele in "Holmes' Surgery" quotes Paget largely, and is evidently of his way of thinking, although he states (and here I think he somewhat contradicts himself) that "where varicocele is very marked and of long duration, true and permanent atrophy of the testis may set in."

We have very strong evidence, on the other hand, to prove that this affection is not so trivial, but that for many reasons it often deserves and demands the surgeon's earnest consideration. Thus Mr. Curling, in his admirable work on "Diseases of the Testicle," writes: "Varicocele tends gradually to impair the nutrition and diminish the secreting powers of the testicle, hence the importance of not neglecting this complaint, though it may produce no painful symptoms. A softening and partial atrophy of the gland, coexisting with varicocele, has come under my

notice in numerous instances; indeed in nearly all the cases in which there was a decided dilatation of the spermatic veins on one side only, the testicle on that side was the smaller of the two." Barwell, who has had a large experience in such cases, believes that the testicle from which the varicocele springs "is not of much use." Erichsen states that varicocele is frequently accompanied by debility of the generative organs and a tendency to seminal emissions and much mental depression. But he points out another danger which attends the presence of varicocele, namely, rupture of one of the distended veins, an accident similar to the bursting of a varix in the leg. One case of this kind, reported by Erichsen, proved fatal from syncope. Van Buren and Keyes write regarding the disease in a somewhat similar strain. So I think it can be proved that varicocele in its more aggravated form is capable of inducing serious pathological changes in the testicle, and hence frequently demands surgical interference.

But even if these changes were not so serious—if it were only for the relief of the pain, dragging sensation, and mental worry which varicocele so often induces, operative measures would still be justifiable. Besides, a very small varicocele often debars the possessor from exercise needful to health, and is a frequent cause of disqualification from active service. I find that during the ten years ending 1853 some four thousand British recruits, or 70.5 per thousand, were rejected for varicocele—a greater number, indeed, than the rejections for hernia. Of French recruits examined in the ten years from 1850 to 1860, 20,550, or 10.05 per thousand, were exempted for varicocele. It must be remembered, however, that the standard of height in the French army is below that in the English, and it is a well known fact that varicocele is much more frequent in tall than short men, the reason being obvious.

I have alluded to the fact that the mental condition of many of those suffering from varicocele is peculiar. Its presence has often a most depressing influence, and I know few affections in which the attention of the person is so concentrated upon his malady as in this. The constant weight in the scrotum, and the

perpetual aching pain up the cord, into the groin and down the thigh, tends to direct his thoughts to his ailment, and his life is in consequence often rendered miserable. Howe relates a case where he operated on a man whose mind was rapidly giving way under the morbid influence induced by the presence of a varicocele. In twenty months after the operation he was quite well and able to follow his usual occupation. "Here," he says, "we have evidence of great good having been done, for not only has the varicocele been cured, but a mental state bordering on insanity has been checked, if not entirely got rid of."

I have thus attempted to prove that varicocele, in some persons at any rate, is not so trivial an affair, but actually demands operative measures for its relief, even if some risk has to be incurred in order to effect a cure. It must be remembered, also, that the necessity for operation does not depend so much on the size of the varicocele as on the symptoms it produces. Thus in varicoceles of large size, the pain and discomfort are sometimes very slight; whilst in others, comparatively small and insignificant, the distress is often very great. A patient, otherwise healthy, and about 40 years of age, consulted me two years since for varicocele. The varix was well marked, although not by any means of very great size, but the neuralgic-like pain from which the man suffered was almost unbearable. He was free from pain only when in the recumbent position. I prescribed all the ordinary anti-neuralgic remedies, both internally and externally, and secured for him a well-adjusted suspensory bandage. He was relieved for a time, but subsequently lapsed into his former condition. He now became desperate, and threatened self-mutilation if the organ was not removed. I consulted with my friend Dr. Fenwick, and we decided that, under the circumstances, castration was perfectly justifiable, and I accordingly performed that operation. The man would not submit to any half measures, such as an operation for the cure of the varicocele itself, as he argued that, in the event of its failing, he might be left in a worse condition than before. I may state that castration has been frequently performed under circumstances similar to those just related. Both Aston Key and Brodie report cases almost identical with mine.

Now, as to the *treatment* of varicocele, I am decidedly of the opinion that any or all of the palliative measures usually recommended should have a faithful trial, namely, cold bathing, the suspensory bandage, the truss, Wormald's silver ring, marriage, &c., but if these fail to remove the trouble, and the symptoms continue after a year or two, I do not hesitate to perform one or other of the following operations:—

The first is the least formidable of the two, and requires only an ordinary amount of skill for its performance. It is, in fact, Ricord's operation, with one or two trifling modifications. This operation, as you are aware, consists in the introduction, in opposite directions, of two loops of wire—one between the vas deferens and the veins, and the other between the veins and scrotum—the free ends being passed through the loops, so that when drawn taut, the latter completely encircle the veins and constrict them. The books recommend us to keep up the pressure on the veins by tightening the wires from day to day over a piece of cardboard or a pledget of lint. This, however, will be found to annoy the patient, and from frequent twisting the wire will sometimes break. I prefer, therefore, to attach a piece of rubber tubing to the wires on either side and pass this round the body. In this way the pressure on the veins is made more equable and constant, and the parts need not be disturbed for days together. In one or two of my earlier cases I experienced great difficulty in removing the wires after the lapse of ten or twelve days, and on one occasion was obliged to break the wire in order to extract it. Of late, however, I have practiced a little device which completely obviates the difficulty mentioned. This consists in attaching to the loop of each wire a short loop of the same material, by pulling on which at any time the main wires can be separated. I was surprised to find, in looking up the literature of varicocele the other day, that Mr. Tufnell of Dublin suggested this slight, but not unimportant, modification of Ricord's operation over twenty years ago, although I have not seen it referred to in any work on systematic surgery. An anæsthetic is seldom required for this operation, although, in the case of a delicate, nervous person, it may be well to give ether, the scro-

tum being made dependent by bringing the patient's hips well over the edge of a table. Where an anæsthetic is not used, however, the best is the standing position. The time required for the division of the veins or their complete closure varies from ten to fourteen days, depending on the age of the patient and the size of the varicocele. I may say that I have performed this operation now seven times, with one failure. In none of the cases was a single unfavorable symptom noticeable.

The other operation is a more formidable one, although not by any means difficult. It is one of the outcomes of Lister's teaching, and is not justifiable unless performed with the strictest antiseptic precautions, including the spray. It consists in making an incision about an inch and a half in length directly over the varicocele, and commencing about half an inch below the external abdominal ring. The veins are then carefully separated from the vas deferens by means of the fingers, ligatured with catgut above and below, and divided by scissors between the ligatures. A small drain, either of rubber or catgut, is placed in the wound, and two or three sutures applied. The parts should then be carefully enveloped in the gauze dressing, care being taken to prevent the urine from contaminating the wound. An anæsthetic should be given, the patient's hips being brought over the edge of the table, and slight pressure applied over the external abdominal ring.

I have here the notes of three cases on whom I performed this operation in the winter of 1882-3, but will not take up your time with the details. The first case was that of an unmarried man, aged 31, with a very large and painful varicocele. I ligatured the veins on Sept. 20th, 1882, and he was allowed to go about with a suspensory bandage (the wound being quite closed) on Oct. 6th, namely, sixteen days after operation.

Case 2nd, 29 years of age, married; varicocele not large, but very painful; operated Oct. 6th, 1882; progressed very favorably till the sixth day, when his temperature went up, and he remained feverish for a couple of days. No cause could be found about the wound for the symptoms. He subsequently progressed very favorably, and was well enough to leave his ward in the hospital on the seventeenth day.

Case 3rd, aged 24, married; had had a slight hemorrhage after connection on one occasion; varicocele large; has not diminished in size, nor have symptoms abated since marriage, two years ago. Operation performed January 20th, 1883; recovery uninterrupted; patient allowed about on the fourteenth day.

I had an opportunity of examining two of these cases some months after operation, and was pleased to find no trace of the varicocele, and there were none of the original symptoms present. For a month or more after the operation the patient should wear a suspensory bandage.

QUARTERLY RETROSPECT OF SURGERY.

PREPARED BY FRANCIS J. SHEPHERD, M.D., C.M., M.R.C.S, ENG.,
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Recent Operations on the Intestines.—Operations on the intestines, formerly so rare, are now of common occurrence. They are called for in cases of strangulated hernia, producing a gangrenous condition of the bowel, in cases of artificial anus due to strangulated hernia, and in cases of intestinal obstruction due to various causes, as constricting bands, tumors, intussusception, &c. As long ago as 1727, Ramdohr successfully removed two feet of intestine found in an inguinal hernia, and up to 1846 only 11 cases of resection were on record, resulting in seven recoveries, one artificial anus, and three deaths. This operation was not performed again (*Medical News*, March 15, '84) until it was revived by Lücke in 1873, and during the last ten years it has been performed many times. The operation consists in relieving the constriction, and if the bowel be gangrenous, drawing it out of the opening, excising the damaged portion and the attached mesentery, and then sewing the cut ends of the gut together, thus re-establishing the continuity of the canal, and returning the parts to the abdominal cavity. Most of the fatal cases reported died of peritonitis. Out of 67 cases, 21 were complete cures, 2 recovered with artificial anus, and 44 (65–67

per cent.) died. According to the writer in the *Medical News* of the above date, the following points should command attention:

1st, To prevent effusion, the lumen of the gut must be temporarily occluded. This may be accomplished by a provisional catgut or silken ligature, but this method is open to the objection of throwing the intestines into folds, which interfere with the proper insertion of the sutures. The occlusion may be effected with a clamp or forceps, or, still better, with the fingers of the assistants.

2nd, If gangrenous, a triangular portion of the mesentery should be removed, and the edges united by suture after the vessels have been ligatured; if sound, it may be ligated in mass. In either case, the mesentery must not be separated from the bowel beyond the points of severance of the latter lest gangrene of the edges of the wound ensue. The gut should be divided at right angles to its axis, unless one end is smaller than the other, when the cut should be made at an acute angle.

3rd, The most important step of the operation is the insertion of the sutures, the material for which should be pure silk soaked in a solution of corrosive sublimate. The safest and most efficient mode of uniting the severed ends of the gut is what is known as the Czerny-Lembert suture. This consists of an inner row of stitches, which are inserted at the distance of one-eighth of an inch from one another, and which include all the coats of the bowel, and an outer row not so close together, each of which includes the serous covering only. If the mucous membrane protrudes too much, it should be cut off on a level with the muscular coat, but the inner stitches should not include it. The accurate approximation of the edges of the wound will be greatly facilitated if the first suture be inserted on the mesenteric side and the second at a point directly opposite. The intestines should be resected only through a sound and undistended portion beyond the seat of infarctions and effusions, as the chief cause of failure is the damaged condition of the gut in the immediate vicinity of the gangrenous portion.

Cases do as well after excision of eight or ten inches of intestine as after excision of two or three inches. Koeberlé

of Strasburg, on one occasion, removed six and a half feet successfully. The question arises, does the resection and suturing of the gut in gangrenous hernia present any advantages over attempting the formation of an artificial anus. Billroth, Dittel, Bergman and other German surgeons favor the latter course, but the writer in the *Medical News* thinks that those who resort to the operation of resection follow the proper course. If successful, the recovery is absolute; if it fails, and the patient survives with an artificial anus or fœcal fistula, his condition is not worse than if the operation had not been practised.

Dr. Porter reports a case (*Boston Med. & Surg. Journal*, May 15, 1884) where he excised a portion of intestine, including part of the ileo-cæcal valve, for the cure of a fœcal fistula. The patient had a right inguinal hernia at the age of eight years, and a similar condition at a later period developed on the left side. Three years previous to her admission to hospital, the hernia of the right side became strangulated, an operation was performed, a portion of intestine sloughed, and an artificial anus was formed in the right groin. Twelve days previous to entrance the hernia in left side became strangulated, and was relieved by operation. The resulting wound, which brought her to the hospital, was healed in two weeks, and then an operation for the closure of the fistula in right side was performed, which was unsuccessful. At the woman's earnest request, Dr. Porter operated for radical cure on Jan. 11, 1884. At that time the woman had two fæcal fistulæ, one above the other, in the right groin; these communicated. They were united by an incision which divided the lower margin of the abdominal ring and laid open the hernial sac; the incision was then prolonged, and exposed the whole sac, making a wound four inches long. The two fistulous openings in the intestine were an inch apart, and were connected by a cut made in a director. The opening in the bowel was then seen to be in the ileum and cæcum, just at their union. The finger could be easily passed into the large intestine, but not into the small, owing to cicatricial contraction involving the ileo-cæcal valve, the opening being only the size of a lead pencil. A dilator was used to enlarge the opening,

and then, with the finger in the opening, the bowel was dissected from the surrounding cicatricial tissue ; this necessitated a section of the abdominal muscles from the external abdominal ring outwards for about four inches. The cicatricial margin of the opening was then trimmed off, and the opening was found to involve about four-fifths of the calibre of the bowel. The edges of this wound were then approximated, but as one side was the small, and the other the large intestine, the edges would not lie smoothly. To obviate this difficulty, a longitudinal cut was made in the small intestine, forming an oval-shaped wound, which could be approximated accurately to the cut edge of the large intestine. The wound was then sewn up with silk sutures as follows: "The needle was entered about half an inch from the wound, penetrating the peritoneal layer, then traversing the muscular layer of the gut, and emerging one-eighth of an inch from the margin of the wound, having left the mucous layer untouched. The needle was then entered at the opposite side of the wound in a corresponding manner, traversing the middle layer, and emerging about half an inch from the wound. Ten sutures were introduced in this way. When these were drawn tight, they rolled in the free margin of the wound, thus bringing two serous surfaces in contact, and turning the cut edge into the interior of the bowel." The intestine was then replaced in the abdominal cavity after additional silk sutures had been placed between the previous ones. The abdominal opening was now brought together with silver wire, the sutures passing through the peritoneum and fascia of the deeper muscles, but not the skin ; the skin was united separately by silk sutures, a large-sized drainage-tube having previously been inserted into the cavity of the abdomen. The wound was dressed after Lister's method, and the operation was performed under the spray. The patient did well, and, with the exception of some high temperatures a couple of weeks after the operation, due to a small collection of pus about the wound, was quite convalescent when the paper was read.

At a recent meeting of the London Clinical Society, held May 9th, Mr. Clutton related a case of *Intestinal Obstruction successfully treated by Operation.* (*Lancet*, May 17th, 1884.)

A boy aged 10, who several times before had attacks of obstruction of the bowels, which always terminated in copious evacuations after enemata, was, on the present occasion, taken suddenly with vomiting and great pain in the abdomen. Opium and enemata proving of no avail, Mr. Clutton decided to operate. He was transferred to St. Thomas' Hospital, and after the administration of an anæsthetic, the abdomen was opened. A collapsed portion of bowel was soon found, and, on bringing it to the surface, a tight, ring-like cord could be felt and seen to be the cause of the strangulation. The band was clamped by two pairs of forceps and divided; each end was ligatured by catgut. After division of the band, the bowel was set free from its strangulation. The band, on examination, was found to have reached from the extreme end of a diverticulum to the wall of the same loop of bowel at a distance of six inches. The abdomen was stitched up, and the boy recovered without any bad symptoms. In the discussion which followed the reading of the paper, Mr. Treves said that Peyrot had collected 29 cases of intestinal obstruction treated by operation, only four of which were strangulations by Meckel's diverticulum. He himself had collected 50 cases, and the mortality was about the same, viz., eight, and thirty recovered. In cases of operation for strangulation due to diverticula, only about one in four recover. Mr. Treves also remarked that the pain of complete obstruction was continuous, as in only 5 out of 50 cases was it intermittent.

Dr. Angus McDonald (*Lancet*, Feb. 9th, 1884) reports a successful case of *Resection of several inches of the Small Intestine in the course of Abdominal Section for removal of an Extra-uterine Pregnancy*. On opening the abdomen, a loop of small intestine was found communicating with the fœtal sac, and, in fact, forming the roof of the sac. The intestine was in a very unhealthy and friable condition, and in endeavoring to empty the fœtal sac, Dr. McDonald injured the bowel. The piece of diseased and injured intestine, amounting in length to about six inches, was removed, and the cut edges of the two ends brought together with a continuous catgut suture, care being taken not to include any of the mucous membranes. The

stitches were put very close to one another. The gap made in the mesentery was also brought together by suture. A fæcal fistula, which communicated with the peritoneum, was closed by freshening its edges and bringing them together with catgut. There was a good deal of hemorrhage from the cut end of the intestine and mesentery, but the stitching completely arrested it. The abdomen and fœtal cavity were then sponged out, and a gutta-percha drainage-tube introduced into the wound, to the bottom of the fœtal sac, and retained by deep sutures. The abdominal wound was stitched in the usual way. For some days the patient was very ill, fæcal matter coming away by the side of the tube, but after a time improvement set in. The bowels from the first moved rather frequently. By the 30th day the drainage-tube was removed, and from that time everything went well. The patient made a perfect recovery.

Prof. S. D. Gross, in a paper read before the late meeting of the American Surgical Association (*Med. News*, May 3, 1884) on *Wounds of the Intestines*, remarked that the first foundation of a rational treatment of lesions of this kind was laid in this country in 1805 by Dr. Thos. Smith of St. Croix. His experiments, twelve in number, were performed on dogs. In 1812, Benj. Travers published a treatise entitled, *An Inquiry into the Process of Nature in Repairing Injuries of the Intestines.* His researches were more especially directed to the elucidation of penetrating wounds, and to the proper management of the bowel in strangulated hernia. Mr. Travers availed himself largely of experiments on dogs. After Mr. Travers, French surgeons gave much attention to this subject, and performed numerous experiments on the lower animals; among these surgeons were Amussat, Jobert, Lambert, Gély and Choisy. In 1843, Prof. Gross himself published an elaborate treatise on the subject, founding his conclusions on a series of seventy experiments performed on dogs. The author of the paper goes on to say that the diagnosis of wounds of the intestines is a matter of primary consideration. If the bowel has escaped through the wound, it will be easy to find the injured part by the egress of some of its contents, and so, also, when there is a

discharge of some of the fæces, &c., through the outer wound, although there be no protrusion of the intestine. But in cases of wounds by a narrow instrument, as a knife, dirk, or bullet, the bowel does not protrude, and the surgeon is uncertain whether it is wounded or not. The two principal signs which must guide us in these cases are tympanites and a discharge of blood by the anus. Tympanites is of great diagnostic value if it supervenes almost immediately after the wound has been received. It is always diffused, and never circumscribed. In connection with the probing of such wounds, Prof. Gross said "the universal sentiment of the profession is opposed to it, on the ground that, while it can do no good, it would often be productive of great harm by disturbing the relations of parts and thus endangering fæcal effusion. I do not think, however, that this rule should apply to the mural wound. Here a probe, properly used, might at least afford useful information in regard to the direction and extent of the external injury." He said two leading indications are to be kept in view in the treatment of wounds of the bowel—the prevention of fæcal effusion and the occurrence of peritonitis. To prevent these accidents, the wound in the bowel, be it ever so small, should be closed by sutures.

Prof. Gross advised the use of the interrupted suture in all wounds of the bowel, whatever their extent or direction. A long, slender sewing needle, armed with strong, well-waxed silk thread, is to be preferred; the sutures should be placed not more than a line and a half apart and one line from the edge of the wound. The needle should be passed deeply through the wall of the bowel, instead of embracing the entire thickness. Prof. Gross, in his paper, held that ordinary sewing silk, well waxed, is much preferable to carbolized catgut, as the latter is liable to give way prematurely. The continued suture had afforded good results in Dr. Gross's experiments in dogs, but the objection to it is that it leaves the edges of the wound in an uneven and puckered condition, which interferes with rapid union. The suturing of the wound having been completed, the parts should be cleansed with a syringe charged with warm water and returned. When the bowel is wounded, but not prolapsed, owing to the

smallness of the mural opening, the external wound should be dilated and the bowel hooked up and sutured, cleansed, and returned. To prevent peritonitis, the abdominal muscles should be relaxed, the bowels locked up with opium, and nothing but a little pounded ice, or iced water, should be given for the first three or four days, and if much gastric distress, a little dry champagne. Oppression from gas must be relieved by injections of turpentine or assafœtida. If peritonitis ensues, it should be treated by leeches and full doses of opium. At the end of five or six days, a laxative of castor oil or sulphate of magnesia should be given.

Prof. Gross does not give any of his own cases, and it does not appear from his paper that he has had any experience in treating wounds of the intestine except in the lower animals.

Dr. Chas. T. Parkes, in his address on Surgery before the last meeting of the American Medical Association, treats of *Gunshot Injuries of the Intestines*. His conclusions, derived from a large number of experiments performed on dogs (*Medical News*, May 17, 1884), are as follows:—

1. Hemorrhage following shot wounds of the abdomen and the intestines is very often so severe that it cannot be safely controlled without abdominal section; it is *always* sufficient in amount to endanger life by secondary septic decomposition, which cannot be avoided in any other way than by the same treatment.

2. Extravasations of the contents of the bowel after shot injuries thereof are as certain as the existence of the wound.

3. No reliable inference as to the course of the bullet can be made from the position of the wounds of entrance and exit.

4. The wounds of entrance and exit of the bullet *should not be disturbed* in any manner except to control bleeding or remove foreign bodies.

5. Several perforations of the intestines close together require a single resection. Wounds destroying the mesenteric surface of the bowel always require resection.

6. The best means of uniting wounded intestine after resection is by the use of fine silk thread, after Lembert's method.

It must include at least one-third of an inch of bowel tissue, passing through only the peritoneal and muscular coats, never including the mucous coat. The everted mucous membrane must be carefully inverted, and needs no other treatment.

7. Wounds of the stomach, small perforations, and abrasions of the intestines, can be safely trusted to the continued catgut suture.

8. Every bleeding point must be ligated, and the cavity of the abdomen must be perfectly cleansed.

9. The stumps of the divided mesentery should be secured to the intestine at the site of the resection.

10. Primary abdominal section in the middle line promises the most feasible opening through which the surgical treatment can be accomplished.

Anæsthesia by the Administration of Ether by the Rectum.—Dr. Mollière, in a note published in the *Lyon Médical*, April, 1884 (*London Med. Record*, May 15th, 1884), states that at the suggestion of Dr. Axel Yversen of Copenhagen he administered ether by the rectum to several patients. In the first case the ether was thrown into the rectum by means of a Richardson's syringe. In five others, an India-rubber tube the size of the finger was introduced into the rectum and put in communication with a bottle containing ether. The bottle was placed in warm water (50°C.), and the vapor of ether gradually passed into the rectum. Whenever tension of the vapor reached a certain point, part of it escaped through the anus. After five or ten minutes the patients complained of drowsiness and a taste of ether in the mouth. Complete anæsthesia could be produced in this way, but it was generally found advisable to let the patient inhale a few grammes of ether. The advantages claimed for this method are the very small amount of ether needed and the absence of a period of excitement. Its advantages are of course obvious in those cases requiring operative procedures about the throat and face.

In the *New York Med. Record* for 3rd May, 1884, there are several reports of a series of cases where the rectal method of etherization was tried. Dr. Wm. T. Bull reports seventeen

cases where ether was thus administered. He does not find that, as a rule, the period of excitement is suppressed, and a much longer period is needed to produce anæsthesia than by inhaling. In most of the cases reported, the anæsthesia had to be completed by administration in the usual way. The patient, in nearly all the cases, experienced considerable distension of the bowel, and at the end of three or four minutes the odor of ether was detected in the mouth. In seven out of the seventeen cases the etherization was followed by diarrhœa, and the stools in two instances contained blood. Dr. Bull comes to the conclusion that ether administered in this way may be very dangerous, as it acts as a severe irritant to the intestines, and that, in old people or the very young, might cause death by diarrhœa and collapse. Five cases are also reported where ether was given by the rectal method in the service of Dr. Shrady at the St. Francis and Presbyterian Hospitals, New York. In one case only was there diarrhœa, and in two of the cases there was a period of excitement. The ether in all cases was administered for short operations, and a prolonged use of the anæsthetic was not necessary. On the whole, in this series of cases, the verdict is most favorable.

In the same number of the *Record* is a letter from Dr. Jas. B. Hunter, who reports six cases of rectal etherization, and says, as the result of this experience, that this method of administering ether is a radical improvement on the old one. The very small quantity of ether used, the absence of strangulation, and struggling or unpleasant sensations, are matters of no small importance, and give the rectal method a decided value.

At the very end of the journal above-mentioned comes the skeleton of the feast. This is a note of warning from Dr. Robt. F. Weir, who reports a fatal case in a child eight months old, who was operated on for hare-lip. At the close of the operation, the little patient was somewhat depressed, but rallied under stimulants; during the night, however, it had several large and bloody stools, and died the following morning.

That this method, when the mode of administration is better understood, will prove a most useful one in short operations on

the face, cannot be denied. It will also be useful as a preliminary to the usual method in cases where ether causes unpleasant sensations, such as strangulation and excitement, when inhaled. But, as Dr. Bull says, in the old, feeble, and very young, it may prove very dangerous by its depressant action and the production of bloody diarrhœa, as in Dr. Weir's fatal case. The amount required to produce anæsthesia by this method seems small, but the quantity given cannot readily be estimated or regulated. It will not suit in prolonged operations, except as preliminary to the method by inhalation.

Forcible Dilatation of the Cardiac Orifice of the Stomach for Stenosis.—Prof. Loreta, on the 15th of March last, performed, for the ninth time, dilatation of the orifice of the stomach. The case was one of a young girl aged 20, who had had ulcer of the stomach, followed by constriction, which had steadily increased. At first, solids, then fluids, entered the stomach with difficulty, the body rapidly wasted, and life could only be maintained by nutritive enemata. Having diagnosed stenosis of the cardiac orifice, Professor Loreta opened the abdomen in the linea alba, and found the stomach thick, small, and contracted. He incised it freely, and passed an elastic bougie through the cardiac orifice to make way for his dilating instrument. This soon overcame the obstacle in spite of efforts to vomit. The œsophagus was found much dilated. The apertures in the stomach and abdominal wall were sutured separately. The operation was performed under chloroform in 30 minutes, and the patient, so soon as she had recovered from the narcosis, to the great surprise of the on-lookers, swallowed three spoonsful of water with perfect ease. The patient, when Prof. Loreta last wrote, had perfectly recovered.—(*Lancet*, April 26th, 1884.

In an address *On the use of Opium as an aid to Surgery* (*Brit. Med. Jour.*, April 26, 1884), Mr. Geo. Pollock says it is in the various conditions of gangrene that opium may be said to stand alone as useful and powerful for good, whether the gangrene be the result of injury in old age, or whether it be in an ulcer in advanced life, kept open by neglect and exposure. In cases of gangrenous ulcers, opium administered internally

arrests or modifies any tendency to ulceration and sloughing, soothes pain, and husbands the powers of the patient. In senile gangrene, Mr. Pollock knows nothing, as regards medical treatment, which can compare with the internal use of opium. It alone will mitigate the pain and render life tolerable till the line of demarcation appears. In such cases opium may be used freely. In traumatic spreading gangrene, opium is of no use; neither is it of any service in gangrene attendant on diabetes, or due to embolism. In the various forms of phagedœna, Mr. Pollock has seen most satisfactory results follow the free use of opium. In such cases opium is not so generally appreciated as it deserves to be, more dependence being placed on local than general treatment. Mr. Pollock has never once in his large experience had recourse to nitric acid in cases of sloughing phagedæna and sloughing sores, nor has he ever found the use of opium to fail in such cases. In all cases of syphilitic phagedæna in private and hospital practice he has trusted alone to the internal use of opium, and has never been disappointed. In ulceration and sloughing of the mouth in young children, Mr. Pollock has found 3 minim doses of laudanum administered every four hours till drowsy, then omit whilst the drowsiness lasts, and continue after it ceases, of the greatest benefit; these cases getting well without any other treatment.

Of the use of opium after hernia operations, and in cancer, little need be said in praise. In cancer, it not only gives relief to pain, but renders life tolerable. The tolerance of opium in many cases is remarkable, the quantity being only measured by its quieting effects. In administering opium, constipation is a thing to be guarded against. Sir Benj. Brodie used to prescribe calomel occasionally when the continued use of opium was requisite. It will be sometimes necessary to relieve the rectum by enemata, and even occasionally to break down hard accumulations of fæculent matter. Not unfrequently opium disagrees in certain individuals; in one it may be the quantity, in the other the quality, of the ingredient. Some cannot take solid opium, whilst Battley's solution agrees well. In others Battley's fails, but codeia can be tolerated, especially as a sedative in bladder trouble complicated with enlarged prostate.

I have this winter had under my care a case of senile gangrene which fully confirms what Mr. Pollock says. First one foot became affected, and full doses of opium were given, the line of demarcation formed, and the gangrenous part removed; then the other foot became excessively painful, and soon after became gangrenous, and after some time a line of demarcation formed and this foot was removed. During all this time the patient was treated with full doses of solid opium to relieve pain, and 8 oz. of whiskey daily to sustain his strength. Without this treatment he would have succumbed to exhaustion; now he is in a fair way to recovery, having been supported by opium till the crisis had passed.

Pressure in the Treatment of Suppurating Buboes.—Prof. O. Petersen treats buboes, after fluctuation is clearly determined, as follows:—A large incision is made, and the cavity of the abscess is cleaned out with a sharp spoon. The bleeding is stopped, and iodoform powder is applied. Then comes the pressure bandage, which is the important factor of this treatment; its application is as follows: First a ball or wad of salicylic cotton, or other soft material made antiseptic by salicylic acid, is formed the size of the cavity and placed over it; upon this wad are placed several layers of the same material; then a second ball or wad, made of tow or oakum, and about four times as large as the first, is placed on this, over this oilskin or wax paper, and the whole firmly fixed with a gauze or elastic bandage. This bandage remains untouched for from seven to ten days. The average length of healing, in a trial of three years of this method, was twenty-three days; previously the average was seventy to ninety days. Twenty per cent. of the cases healed under one bandage, twenty-five under two, and twenty under three; more than seven bandages were in no case necessary. The average number of bandages was two.—(*Centralblatt f. Chirurgie*, Nov. 1883; quoted in *Practitioner*, April, 1884.)

I have used a somewhat similar treatment for the last two or three years, and have been well pleased with it. I have used borated cotton in place of salicylic. The pressure is the most important part of the treatment.

Iodoform in Erysipelas.—In an article in the *London Practitioner* for May, 1884, Mr. C. C. Burman states that in his experience the most successful external application for erysipelas is a solution of iodoform-collodion; it promptly relieves the burning pain and seems to arrest the progress of the disease, and in the cases where it was applied, there is a remarkable freedom from irritation during the period of desquamation. It is the experience of most surgeons that iodoform does not protect against erysipelas. I should imagine that in the cases referred to by Mr. Burman the good effect depended more on the collodion than the iodoform. However, it is a remedy worth trying. It probably acts in the same way as white lead painted on, viz., by protecting the inflamed surface from the air.

Cholecystotomy.—Mr. Lawson Tait (*Brit. Med. Jour.*, May 3rd, 1884), in a note on the above subject, states that the patient upon whom he first performed cholecystomy in 1879 is still living. He has performed the operation thirteen times, and all the patients have recovered. Mr. Tait does not approve of Sir Spencer Wells' suggestion that after opening the gall-bladder and removing the gall-stones the wound in the gall-bladder should be closed by a continuous suture without attaching it to the abdomen. It is, he says, a matter of extreme difficulty to be quite certain that all stones are removed from the duct, and if one remains, and the gall-bladder, which fills up with its own secretion even if no bile enter it, would, by its efforts to expel its contents, re-open the wound and cause extravasation into the peritoneum. The same reason exists for not putting into practice Langenbuch's proposal to remove the gall-bladder; if the gall-bladder were removed when a stone was lodged in the common duct, the bile must all flow into the peritoneum. In some of Mr. Tait's cases, biliary fistulæ have remained, some no larger than pin-holes. In one case, where a stone remains in the duct, every drop of bile comes through the fistula; he has several times tried to close the fistula, but without success, as the endeavor always brings on agonizing colic. In this case he proposes to open the abdomen again, about an inch to the inner

side of thegall-bladder, and to crush the obstructing stone *in situ* by means of a pair of padded forceps.

Whilst watching these interesting cases of biliary fistula, Mr. Tait has read much about the functions of the bile, and finds that all the experiments from animals have been futile in settling even the most elementary facts of the influence and uses of human bile. He has not seen the slightest evidence to prove that either quantity or quality of food, or any drugs that were used, as morphia, calomel, podophyllin and rhubarb, have the slightest effect on the quantity or character of the secretions. None of the patients have suffered even when all the bile came through the fistula—indeed, one patient gained in weight and greatly improved in health. The stools are almost milk-white, and there is not the slightest evidence of the flatulence and decomposition which is said in text-books to be the result of biliary fistula.

Reduction of Incarcerated and Strangulated Herniæ by Faradisation.—In *Vratch*, No. 23, 1883, Lev, Koltchevsky and Voloshkevitch report cases of strangulated and incarcerated herniæ reduced by faradisation, where taxis, warm baths, ether irrigations, &c., had failed. In some of the cases the reduction was accomplished in a few minutes; in others, in a quarter of an hour. One of the electrodes is placed alternately to the neck of the tumor and to the hypogastrium, and the other to the fundus of the hernia.—(*Lond. Med. Record*, April, 1884.)

Correspondence.

LETTERS FROM BERLIN.

(From a Special Correspondent.)

BERLIN, May 1st, 1884.

THE CONGRESS OF GERMAN SURGEONS.

The surgical congress which closed on the 20th ult. brought together a majority of the well-known surgeons of Germany, and has been in every respect a great success. The eminently scientific character of many of the papers, and the brilliant series of cases which were shown, told of the advanced position of German surgery to-day and of a combination of the *Science* and of the *Art* not to be found in every country. The congress opened on Tuesday evening, the 15th, with a reception in the Hotel-du-Nord. The regular meetings were held in the aula of the University and in the theatre of the surgical clinic. I shall give a brief account of the papers and cases which seem to me of general interest.

Dislocation of the Cervical Vertebræ.—Dr. Wagner of Königshütte (a mountainous and mining district) gave an account of five cases, showing two of the patients and several preparations. The first case, a man aged 50, was thrown from a railway carriage and fell on his neck. He was unconscious for an hour; paralysis of the legs and arms—latter not complete. Legs anæsthetic, trunk and arms with normal sensibility. Head bent strongly back; neck muscles tense. Slight passive movement of the head possible; no disturbance of deglutition. The next day the arms and trunk were anæsthetic. Examination under chloroform gave no positive evidence of the nature of the injury. Death took place on the third day. On the body it was impossible to find any alteration in the cervical vertebræ until after removal of the muscles, when the 6th was found dislocated forwards. The second case was that of a girl aged 15, who fell from a height of 18 feet. Complete paralysis and anæsthesia. Dr. Wagner saw her 14 days after. There was then extreme flexion of the head backwards, so that the face was directed upwards. Neck could not be moved much. The processes of

the cervical vertebræ could be felt; that of the 6th was tender, and by careful palpation, crepitation could be felt. A diagnosis of fracture of this vertebra was made, and the head placed in suitable apparatus for fixation. Considerable improvement followed; the paralysis began to disappear, but death took place after fourteen days from decubitus. The dissection showed luxation backwards of the 6th, with tearing of its ligaments. The next patient was a man on whom a stick of wood had fallen. On admission to the hospital there were paresis of the left arm and leg and of the detrusors, and great pain in the back of the head. The muscles of the left side of the neck were tense, and there was a marked projection to the left of the process of the 3rd cervical vertebra, and a decided irregularity could be felt in the pharynx. The reduction was effected by the Richet-Hueter method, and after fourteen days the starch neck-bandage was removed. The patient was exhibited, as well as photographs, showing the position of the head after the accident. The fourth patient, who had also received a blow on the neck, had much more severe symptoms. Complete paralysis of the legs, of the left arm, and of the detrusor vesicæ. Head turned towards towards the right. Examination under chloroform revealed no abnormality in the position of the processes which could be felt, only a greater sensibility of the 5th, and there was tension of the left cervical muscles. The diagnosis was rotation—luxation of the 5th vertebra to the left. The reduction was effected by turning the head to the right side and then bending it to the left and then to the opposite side. The luxation was reduced with an audible snap. The next day the condition of the patient was much improved, but it was not until two months that he began to get about, and even now there are signs of affection of the cord, as the left arm is wasted, flexed, and has tremors. In all other aspects, the patient, who was exhibited, appeared quite well. In the fifth case, a boy of five, fell on his head, and shortly afterward the mother noticed its remarkable position, but he complained only of difficulty of swallowing, pain and creeping sensations in the left arm. The head was bent strongly to the left, and when Dr. Wagner saw him, fourteen

days after the accident, examination showed a deviation of the 5th cervical process to the left, and a prominence also of the transverse process. From the pharynx there could be felt a projection of the body of the 5th, which was also twisted to the right. By strong bending to the left, and rotation to right, with moderate traction after three attempts, the reduction was audibly effected. The child recovered completely.

In the discussion which followed, Dr. Schede of Hamburg mentioned two cases of rotatory luxation. One, in a long-necked, thin man, occurred in a curious way whilst he was washing his neck very energetically, when suddenly the typical oblique fixation of the neck took place, which, in narcosis, was readily reduced. The other case was in a girl who fell off a rocking-horse: owing to the thin neck the luxation was easily diagnosed and readily reduced. There were no spinal symptoms in either case. Other cases were narrated by members. Dr. Wagner's preparations of luxations and fractures of the vertebræ were unusually fine. He has had quite an exceptional experience in these cases.

Fracture of the Odontoid process.—Prof. Küster of Berlin showed the patient, a young girl aged 18, and narrated the case. In January, 1882, her master had seized her by the hair and beaten her head several times against a beam. After this treatment she was seen to walk across the street. In the evening she complained of pain in the neck, and went to bed early. When she attempted to get up next morning she fell, and was found by her father in a convulsion, but conscious. She was put in a carriage and taken two miles to her home, and during the journey she remained stiff and speechless. She was paralyzed, could speak only with difficulty, and from time to time had convulsions. From March until September she remained without any special change. When admitted under Dr. Küster's care she lay stiff in bed, sensorium free, and she answered questions rationally, but with indistinct articulation. Pulse 120; breathing frequent, pectoral. Patient could only lift the legs a little. Reflex excitability extraordinarily increased; sensation not disturbed; bladder and rectum normal. When sat up in

bed the head fell forwards, the face became blue, and the breathing hurried. Examination showed that the process of the 2nd cervical vertebra was somewhat prominent, and there was an evident projection in the pharynx, just below the basis cranii. The treatment consisted in an extension of the head by a 10 kilogramme weight. In five weeks the result was extraordinary. The arms and legs could be moved freely, and the speech improved. A leather cravat was fitted to the neck, and she was allowed to go about. The improvement has persisted, and she was shown to the congress in good health. An evident projection of the 2nd spinous process still persists. The symptoms pointed to compression of the cord very high up, and the projection of the spine could be explained by three conditions: either fracture of the anterior part of the atlas, laceration of the transverse ligament, or fracture of the odontoid process. The uniformity of the projection in the pharynx was against the first view; tearing of the transverse ligament was very improbable, and had never been observed, and by exclusion, he concluded that the not very uncommon fracture of the odontoid process had taken place.

The question was raised as to the possibility of hysteria, but Dr. Küster thought that it could positively be excluded.

Transplanting Teeth.—Dr. Bidder of Berlin showed an incisor tooth which he had extracted on account of an alveolar abscess in 1879. Finding it quite sound, he cleansed the cavity and the fang with carbolic acid, and replaced the tooth. It stuck fast, and remained until 1882, three years, when it became loose, and at last fell out. The fang was almost absorbed by the granulations which existed in the socket.

The transplantation of teeth, of late years so much talked about, is in reality a very old affair. I have seen somewhere an advertisement, taken from a New York newspaper of about the year 1800, offering so much a-piece for sound and live incisors for the purpose of transplantation.

A new mode of Amputation at the Middle of the Foot.—Prof. Küster showed a girl, aged 4, whose foot had been badly crushed on the outer side by a waggon wheel. Gangrene fol-

lowed, and only the skin over the 1st metatarsal bone remained intact. In amputating at the tarso-metatarsal joints, he left the 1st metatarsal bone with the great toe, and, as the result proved, the girl has a very useful foot, and goes about quite well. The big toe has become strongly adducted.

Circular Goitre.—Dr. Credé, jr., of Dresden, showed a patient from whom, two years previous, he had removed a large thyroid which encircled trachea and œsophagus. The operation was performed on account of the attacks of dyspnœa; there was paralysis of the left vocal cord. For fourteen days after the patient had to be fed through the sound on account of difficulty in swallowing. In three and a half years Dr. Credé had, on twenty-two occasions, extirpated the thyroid, in two-thirds of the cases totally. In one case. a girl aged 16, death from meningitis followed, but as she had had a meningeal attack a year and a half before, it remains doubtful if the operation directly induced the fatal one. In the discussion which followed, Dr. Baumgärtner demonstrated several specimen of encircling goitre which he had removed, all successfully.

Primary Sarcoma of Spleen; Extirpation.—Dr. Hacker of Vienna demonstrated the specimen, which was removed successfully by Prof. Billroth from a woman aged 40, who had for ten years noticed a swelling in the left side. For two months before the operation it grew rapidly. The irregularity of the surface rendered a diagnosis of neoplasm probable. Part of the pancreas had to be removed with it on account of the strong adhesions. The interest of the case lies in the extreme rarity of sarcoma of the spleen.

Dr. Credé, jr., remarked that the patient from which he had extirpated the spleen in 1881 was now quite well and following his trade.

Dr. Czerny also stated that the patient from whom, five years before, he had removed a moveable spleen showed no blood changes, but had at times severe nervous symptoms.

Cachexia Strumapriva.—Under this name Kocher describes the peculiar symptoms which in some cases follow removal of goitre. Dr. Baumgärtner of Baden-Baden stated that four of

his 19 cases presented these symptoms, the nature of which may be understood from the following history: A girl, aged 16, one year after total extirpation of a bronchocele, presented a great change in her expression. The face was puffed, and there was a general dullness of body and mind. These symptoms got worse within six months, and were accompanied by difficulty of breathing. Before the removal, there had been paralysis of the left vocal cord, which had improved after the operation. Within a year the rima became almost closed from paralysis of the abductors, and tracheotomy had to be performed. In all the cases, he supposed the trouble to be involvement of the recurrent laryngeal, not at the time, but subsequently, through the sympathetic (?) The general changes were probably brought about by the deficient oxydation of the blood. In some of Kocher's cases there was atrophy of the trachea—possibly from injury of blood-vessels of this part. The points in the operation which were specially insisted upon by Dr. Baumgärtner were the care of the recurrent laryngeal and of the tracheal blood-supply.

Hernia diverticuli intestinalis.—Meckel's diverticulum has on several occasions been found strangulated in the femoral ring. Dr. Busch of Berlin demonstrated a specimen obtained from a man aged 53, who had had for years a small rupture, for which he had worn a truss. At the beginning of the month he was attacked with great pain in the groin, with swelling of the abdomen, and signs of peritonitis. When brought to the hospital he was sinking fast. Nothing was found in the crural region to indicate a strangulation. The autopsy showed the abdomen filled with fæces and at the margin of a diverticulum on the ileum a small perforation. Dr. Busch supposed that the diverticulum had got caught in the ring, and the pressure of the truss had been sufficient to produce a small ulcer leading to perforation.

Ogston's Operation.—From the opinions expressed by many of the leading surgeons, this mode of operation is not much in favor; indeed Prof. Ogston, who was present at the congress, has of late abandoned it. However that may be, certainly Dr. Partsch, one of the assistants at the Breslau clinic, presented a most favorable report on 23 cases operated upon from '78–'84.

Patients were all of the laboring class, and the disease had in no case originated in Rachitis, but in the pressure and strain entailed by the work. The ages ranged from 15 to 19. There was no change made in the operation. Spray was not employed. Photographs were shown of many of the cases, and four patients were presented, the results in which secured everything that could be desired. In the discussion, Professor Volkmann spoke strongly against the operation, while acknowledging the brilliant results obtained by Dr. Partsch. No one could guarantee that in a given case suppuration of the knee would not occur, and many instances of the kind had never been published. Just as good results, he thought, could be obtained by other and simpler methods.

Extirpation of the Larynx.—This operation has not been regarded by the profession with any great degree of favor. Any one who had the opportunity of seeing the patients presented by Drs. Hahn, Schede and Küster must have had any previous notions of the uselessness of the operation quickly dispelled. Dr. Hahn, Director of the Surgical Department of the City Hospital, Berlin, narrated five cases and showed three patients. The other two had died of pneumonia shortly after the operation. The first man shown had been operated upon 3½ years before, and was now 71 years old, and appears quite well. The other two had only half the larynx removed, and the function of the organ was fairly well preserved; both could speak quite audibly. The statistics which Dr. Hahn gave of the operation were as follows: Of 52 total extirpations for cancer, 24 had died from the effect of, or shortly after, the operation, whereas of the 11, half operations only, one had so died. After the total extirpation, 14 relapses had occurred; after unilateral, only 3. Dr. Hahn operates as follows: An incision is made at a level of the hyoid bone, towards the diseased side, and from this another at right angles, in the median line, as far as the cricoid. After removing the soft parts, and tying vessels, the thyroid cartilage is divided, and an inspection made of the extent of the disease. If only half, then that part of the thyroid is cut out, and with it a portion of the cricoid and the arytenoid cartilages.

Dr. Schede of Hamburg presented a patient from whom, in 1882, he had removed half of the larynx for cancer. The most interesting feature of this case was the retention, in a high degree, of the function of the larynx, and the man could talk quite fluently, although in a monotone. With the laryngoscope, it could be seen that a sort of new vocal cord had formed on the diseased side. The recent statistics which Dr. Schede gave seem certainly to justify the operation, particularly the unilateral extirpation. Taking the 32 last operations, eight had died from the effects of the operation, six had recurrence of the disease within nine months, three had died of intercurrent affections, and fifteen still lived. The earlier it was recognized and extirpated, the better is the result.

Prof. Küster also showed a patient, a doctor, from whom he had removed half the larynx for cancer three years before. This man also spoke with wonderful distinctness.

Resection of a Cancer of the Small Intestine.—Dr. Schede of Hamburg narrated the case and showed the specimen. The patient was seen in May of last year, and presented symptoms of an abdominal growth, which could be felt to the left, just above Poupart's ligament. For some months there had been digestive disturbances and emaciation. The incision was made parallel to the ligament, and the abdominal walls were here found infiltrated, and, to the surprise of the operator, it was connected with the small bowel. It was removed, and the ends of the gut stitched together with silken continuous sutures. The patient made a good recovery, and in February of this year there was no sign of relapse. At the end of last month he was admitted with fæcal vomiting, which was, of course, attributed to stoppage at the site of the former operation from return of the disease. The abdomen was opened for the purpose of making an artificial anus, when it was found to be an incarceration of the bowel by a ligament. This was cut through and the gut released, and on the same day patient had seven stools. Everything progressed favorably until the fifth day, when the man had a rigor and symptoms of apex pneumonia, from which he ultimately died. The specimen showed the healed intestine, with no sign of a

return. Dr. Schede remarked that the cases of resection for total obstruction had been very unfavorable. Of 19 such cases all had died; but, on the other hand, when done early, the results were extremely good. Of the 13, three had died of shock, and of the remaining 10, eight had recovered.

There were three other interesting specimens of abdominal surgery shown, but I did not see them; two by Czerny of Heidelberg, of resection of the stomach, and a case of gastro-enterotomy for stenosis of the first part of the duodenum, due to ulcer.

Wound Treatment.—Nothing very new on the subject was brought out. Dr. Bruns of Tübingen spoke of his continued success with the sublimated wood wool, the material now so much used in paper factories. It seems to make a very nice dressing, is soft, elastic, and very absorptive, and last, but not least, very cheap. Dr. Schede and Dr. Mikulicz (of Cracow) gave their experience with the sublimate—both very favorable, particularly the former, who spoke of its extraordinary protective power against erysipelas. Dr. Schede of Hamburg, who has one of the largest surgical clinics in the world, had not had a single case of the disease originate in his wards during the two years in which he has employed it. Dr. Leisrink of Hamburg showed prepared bog moss (*sphagnum*) for wound-dressing, with and without the sublimate. It seemed both dirty and dusty, and not to be compared with the fine wood-pulp, which is as soft as cotton-wool and very clean.

From 8 to 10 a.m. of each day the members visited the surgical clinics, of which there are five chief ones,—the Charité, Prof. Bardeleben; the University Clinic, Prof. Bergman (these are the clinics frequented by the students); the City Hospital, Dr. Hahn; the Augusta Hospital, Professor Kuster; and the Bethanien, Dr. Roser. The directors of the surgical department of each of these institutions is a permanent salaried officer, with, in some cases, fine quarters in the Hospital, and in all quite unrestricted as to private practice. Each one has from three to five skilled assistants, who remain with him for some years, and are usually among the aspirants for the surgical vacancies at the other German Universities.

The medical congress was held on the following week, and was also very successful.

The summer session, advertised to begin on April 15th, has only just opened. Punctuality is not a German virtue.

BERLIN, May 18, 1884.

THE KOCH DINNER, &C.

It must, indeed, have been a proud moment for the whilom district physician, Robert Koch, on the evening of the 13th inst., when some 500 of his brethren met to do him honor on his return from India and Egypt. The reception was, as remarked to me by one of the privat-docents, unprecedented and unparallelled in Berlin. It was, indeed, a gay festival. The guests assembled in the ante-room of the Hôtel-Central at 6.30 p.m., and a little before 7 o'clock Prof. Bergman, the chairman, entered with Dr. Koch, and the guests immediately adjourned to the winter garden of the hotel, where eight tables had been prepared. To the right of the chairman sat Dr. Koch, Prof. Virchow, Dr. Strück of the Public Health Department, and Professors French, Leyden, Schröder and Bardeleben; to the left sat the two assistants on the commission, Profs. Dubois-Reymond, Hirsch, Volkman (of Halle), and Küster. Prof. Bergman, after greeting the guest of the evening, and congratulating the commission on its safe return, referred to the pride which all felt, from the Kaiser to the lowest citizen, at the fresh honors to German science which had resulted from the labors of Dr. Koch. "It was not," he said, "the courage with which you went forth to investigate the fatal plague which we admire. Many of those about me have done the same thing. He who (Virchow) went to Sperrat and Schliessen, to the typhus epidemic, threw his life on the hazard just as much as the man who examined the bodies of cholera patients in the dirty huts by the Ganges. Not one of us, indeed, would tarry a moment to think of our own health when the life of a patient is concerned. The device of our profession is that of the candle—'*aliis serviens ipse consumor*.'" "Nor do the consequences which are expected to follow blind us, as they do many who now cry 'hosanna,' thinking that there will be no more

cholera; with us it is different. Our recognition of the value of your work would not have been changed in the least had the fatal disease followed hard upon your heels and entered Berlin with you." "We marvel, also, at the ceaseless industry of our colleague, who does not know how often the spirit of a country physician is broken, and his thinking powers weakened, by the endless round of visits. The reality of the waggon-rattle fits badly with the ideal of scientific work. But the district physician of Wollstein knew how to glean some hours from the restless and driving activity of practice, and, in the space of ten years, has concluded the series of brilliant observations from the discovery of the spores of the bacillus anthracis to that of the common bacillus of cholera."

These extracts will give but a feeble idea of Prof. Bergman's stirring address. Then followed two congratulatory addresses from the chief medical societies of the city, after which Prof. Virchow delivered a most humorous and characteristic speech. Dr. Koch's reply was extremely modest; he claimed only to have discovered improved methods of observation. He believed that one important result of the commission would be, if the English Government gave proper assistance, the limitation of cholera to its native place in India.

The Government has voted Dr. Koch 100,000 marks (25,000 dollars), and there is some talk of establishing a public health department in the University and making him Professor of Hygiene. Dr. Koch is about 40 years of age, a graduate of Göttingen I believe, and for many years was the district physician in Wollstein, in which position he made his earliest investigations, and began the improvements in methods which led to the discovery of the bacillus of tuberculosis. This feature of his career is particularly pleasing, and it reminds one of that other country physician who, nearly a century ago, made the memorable observations on cow-pox.

Reviews and Notices of Books.

A Treatise on Bright's Disease of the Kidneys: Its Pathology, Diagnosis and Treatment. With chapters on the Anatomy of the Kidney, Albuminuria, and the Urinary Secretion.—By Hy. B. Millard, M.A., M.D. With numerous original illustrations. New York: Wm. Wood & Co. Montreal: Dawson Bros. 1884.

The first forty pages of this work are devoted to a description of the anatomy and physiology of the kidney. The latest views on both these subjects are presented in a succinct, but yet complete, manner. One of the best chapters in the book is that dealing with the significance of the existence or non-existence of albumen in the urine, and the general conditions of its occurrence in health and disease. An account is given of Drs. Capitan and Chateaubourg's experiments and observations on the so-called "physiological albuminuria." These observers examined the urine of 94 apparently healthy soldiers five hours after a meal, with the following result: The urine of 76 (or 80 per cent) contained albumen. Forty of the 76 specimens of urine showed only a faint trace; the remainder, however, presented a well-marked cloud. Tauret's test (the double iodide of mercury and potassium) was the reagent used in testing these cases. It shows decided traces of clouding when both heat and nitric acid fail to do so. Albumen is also not infrequently present in the urine of children who are to all intents and purposes healthy. The influence of severe intellectual exertion in producing physiological albuminuria is shown by the observations of the two French physicians named, who found that the urine of 46 out of 50 pupils at one of the Government schools, who were hard at work preparing for examination, contained albumen. Cold bathing, sexual excitement, and menstruation have also an undoubted influence, according to the same observers, in making albumen appear in the urine. With the tests commonly used (heat and nitric acid) it is admitted by Millard that it is impossible to demonstrate the existence of albumen in anything like the same proportion of cases. He cautions against unnecessarily alarming a patient

simply because albumen has been found in his urine. He says that when albumen exists in the urine in such minute quantities as to be undetectable by nitric acid, it is not of much practical importance as indicating the existence of nephritis. The microscope is, in doubtful cases, the only reliable test whether nephritis exists or not. After detailing the causes of albuminuria other than nephritis, the author takes up the tests for albumen in the urine. Heat, nitric acid, picric acid, double iodide of mercury and potassium, sodium tungstate, and the brine test, are all dealt with in detail. Speaking of the double iodide of mercury and potassium test (Tauret's), he considers that it is the most delicate test for minute quantities of albumen. The possible sources of error with this test are the peptones, mucus, and presence of vegetable alkaloids in the urine. All these substances, with the exception of the mucus (which becomes filamentous), disappear on heating. The formula for the preparation of "Tauret's test" is as follows:

Potassii Iodidi, - -	3.22 grammes.
Hydrargyri Bichloridi, -	1.35 "
Aq. Distil. (ad) - -	100 C.C.

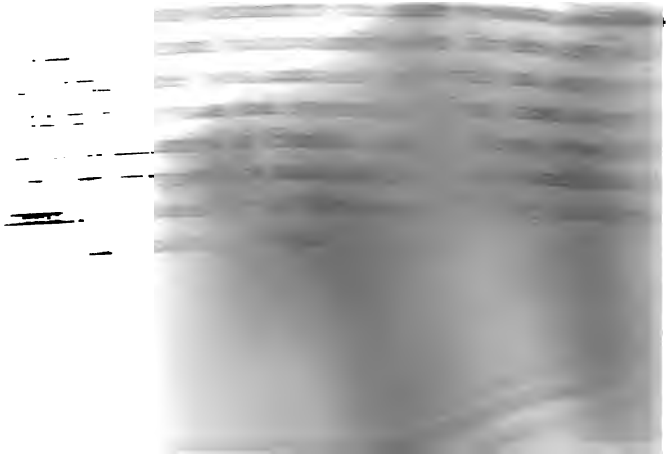
In testing for albumen with this solution, it is important that the three following points should be attended to: 1, That the urine should be perfectly clear, being boiled, if necessary, with potash and filtered. 2, That it be acidulated (citric or acetic acid). 3, That a strong, clear light should be employed. It is preferable to pour the reagent into the bottom of the test tube, and allow the urine to trickle down upon it, drop by drop, along the side of the tube. When the quantity of albumen is small, as much urine should be added as will equal the amount of the reagent. The cloud formed is bluish-white. If the urine be heated, the cloudiness will be increased and flocculi formed.

After devoting a chapter to the consideration of the significance of urinary casts, the author proceeds to discuss the individual varieties of Bright's disease. Under this term he understands all forms of nephritis, and he considers that all forms of inflammatory processes in the kidneys may be comprised in the three varieties which he adopts—1, Croupous nephritis; 2, Interstitial

nephritis; 3, Suppurative nephritis. The two last are self-explanatory. By the term croupous, he means what is now commonly called the parenchymatous variety of Bright's disease. He is in accord with most recent observers in regarding interstitial and parenchymatous nephritis, not as essentially distinct diseases of the kidneys, but as identical in character, but differing in the degree in which the connective tissue and the epithelia are respectively effected. "They always coexist, and one cannot exist without the other being developed at least in some degree." The waxy and fatty kidney he considers simply an intercurrent or subsequent development upon one of the above forms, and not a condition independent of other lesions of the kidney.

We will not dwell on the manner in which the author deals with the nature, symptoms and causes of the different varieties, but will pass on to what we consider the best part of this, on the whole, very creditable treatise. We refer to the treatment.

In speaking of the symptomatic treatment of acute parenchymatous nephitis, the author claims for diuretics the most important place, and of diuretics he claims that digitalis and the convallaria majalis (lily of the valley) are the most trustworthy. Both of these agents act in a similar way as diuretics, viz., through their power of increasing the blood-pressure. Neither of these have any direct influence in increasing the quantity of urine. Speaking of agents that have a direct influence in lessening the quantity of albumen excreted in both acute and chronic nephritis, the author claims the highest place for the *tannate of sodium*. It is prescribed in doses of from 10 to 20 grains three or four times daily, well diluted in water. Reference is also made to the alleged properties possessed by gallic acid in diminishing the quantity of albumen. Allusion is made to the effects of nitroglycerine in diminishing increased arterial tension, no matter whether this is due to chronic kidney disease or arterial fibrosis, and with the diminution of the pressure there is marked relief. He considers, however, that the doses usually recommended ($\frac{1}{100}$ of a drop) are too large, producing great fullness and throbbing of the cerebral blood-vessels in many cases. Mention is made of an action supposed to be possessed by certain mercurial



gives a long list of cases where one or more of these agents was the sole treatment employed, and where the result was certainly not any better than if the disease had been allowed to pursue its course without any treatment. There certainly is strong reason for believing that none of the agents mentioned have a direct influence in curing gonorrhœa. Those who claim virtues from them say it is owing to the fact that they are eliminated by the urine, and in this way influence directly the diseased structures. If this were so, the injections of these substances ought to be efficacious, but the contrary has been proved. Full details are given of the method of carrying out the local treatment of gonorrhœa, especially where the disease is confined to the anterior portion of the urethra. We, however, miss a description of Altzmann's excellent apparatus for the irrigation of the posterior urethra. In many respects the work is, as might be expected, of an encyclopædic character. We, however, find no mention of a very important subject—the "tripperfäden" (gonorrhœal threads). While these threads are in the urine, a patient is not free from his gonorrhœa, and their disappearance is the best evidence that the disease is completely cured. Weeks after the discharge has stopped they can be found floating in the freshly passed urine. While they are present it is quite easy, by any excesses, to have a return of the acute urethritis, and many of the cases of gonorrhœa said to be cured by a few injections are undoubted instances of simply an acute attack grafted on a chronic one.

Mr. Milton gives a very complete account of the different complications of gonorrhœa—both local and general. His description of gonorrhœal rheumatism is particularly full and instructive. In this very distressing and troublesome affection he has found quinine answer best. He recommends it to be given in solution with sulphate of magnesia.

San-Remo Climatically and Medically considered.—By Arthur Hill Hassall, M.D., &c. New edition. London: Longmans, Green & Co. 1883.

This neatly gotten-up and interesting book may be considered

as a new edition of Dr. Hassall's well-known work, "San Remo and the Western Riviera." San Remo is the last and most easterly of the world-renowned health-resorts situated in that district of the Alpes-Maritimes known as the Riviera di Ponente. The author claims for San Remo certain important advantages over the other resorts of that section. Thus he proves that the much-dreaded mistral, the curse of the Riviera, is not of such frequent occurrence there, and does not blow with such violence as in the case of many places situated more to the west. This town has a remarkably small rainfall also, ranking next to Malaga in that particular. However, while specially favored in some respects, San Remo has certain disadvantages. Thus, being in Italian territory, the traveller from the north is subjected to additional customs surveillance, and this often means delay and serious discomfort to the invalid. Then there is the greater difficulty experienced in obtaining suitable food, as all articles of English manufacture are exceedingly dear. Tea, sugar, bread and salt are very expensive. The manufacture of salt is a Government monopoly, and so sharply do the authorities look after this item in the tariff, that one is not allowed to take even a pailful of water from the sea, for bathing or other purposes, without a special permit. Hence persons of limited means can live much more economically in that portion of the Riviera under French rule than at San Remo, or any other place on the Italian side. The author discusses at considerable length the botany and zoology of the district about San Remo, and, with certain data arrived at from the study of these, attempts to prove much with respect to the climate and its curative properties. It is a mistake, however, to claim anything peculiar in this regard for San Remo, because of the similarity of the entire western Riviera. Dr. Hassall gives much valuable information for the guide of invalids visiting these parts, and concludes with an appendix describing fully the walks and various excursions that may be taken in the neighborhood of San Remo. We have read this book with very great pleasure and interest, and can confidently recommend it to any member of the profession seeking information of the kind contained therein.

A Treatise on Syphilis in New-born Children and Infants at the Breast.—By P. DIDAY, ex-Surgeon to the Hospital de l'Antiquaille, Lyons. Translated by G. WHITLEY, M.D. With Notes and an Appendix by F. R. STURGIS, M.D., Professor of Venereal Diseases in the New York Post-Graduate School, &c. New York: William Wood & Co.

The Library of Wm. Wood & Co. has received a valuable addition in the above publication. The subject of syphilis in young infants is one of universal interest both to physicians and to surgeons. Its intrinsic importance always claims our best attention with reference to both the actual subject of it and also those who may be accidentally brought in contact therewith. There is no class of cases in which the practitioner stands more in need of knowledge, skill and tact in their management. In private practice, a great many most delicate questions will arise in connection with proposed marriages, with suspicious conditions after marriage, and with possibilities of infectious states of new-born children. In dealing with these and many other problems which will at once suggest themselves, the prescience and the firmness of the medical man may be of the utmost importance. M. Diday is one of the recognised authorities on syphilis, and his extensive researches have been carried on during a long series of years. Many of the problems in infantile syphilis remain yet unsolved, and hence the undiminished interest attaching to its study. This book, together with that of M. Fournier on Syphilis and Marriage, form, together, probably the best presentation of the entire subject in accordance with modern scientific views which we have. The notes by Dr. Sturgis are very useful and appropriate, and the appendix by the same author contains a good deal of collateral matter which adds to the completeness of the work.

Veterinary Medicine and Surgery in Diseases and Injuries of the Horse.—Compiled from standard and modern authorities, and edited by F. O. KIRBY. Illustrated. New York: Wm. Wood & Co.

This volume forms the last of Woods' Library for 1883. It

presents briefly the various diseases and injuries of the horse, as commonly recognized, with their symptoms and appropriate management. It is not at all a scientific book, and does not seem anywhere to add to what is already found in most of the good works on farriery and veterinary lore. It is hardly of the character which we might have expected from its finding a place in this generally excellent series.

Practical Pathology: A Manual for Students and Practitioners.—By G. S. WOODHEAD, M.D., F.R.C.P.E., Demonstrator of Pathology in the University of Edinburgh, Pathologist to the Royal Hospital for Sick Children, &c. With 136 colored plates. Philadelphia: Henry C. Lea's Son & Co.

In a book of this kind the character of the illustrations is of unusual importance. A description of microscopical sections is almost useless. When, however, one is presented with a facsimile of the object as actually observed under the microscope, then the lessons conveyed by it are fully appreciated. The colored drawings in this work are admirably executed and form a striking feature. Almost every department of pathological histology is thus illustrated by actual original drawings. Complete directions are given for examining most successfully all sorts of diseased structures; and most carefully-written descriptions of the abnormal appearances are to be found in every chapter. It is certainly one of the most useful books for the modern student of pathology which we know of.

Elements of Practical Medicine.—By A. H. CARTER, M.D., Lond., M.R.C.P.L., Physician to the Queen's Hospital, Birmingham, &c. Second edition. London: H. H. Lewis.

This book, of very reasonable and handy dimensions, has been compiled chiefly with the view of "bringing the essentials of the subject within the grasp of those who are not disposed or have not the leisure to read the large and complete works" which form our standard text-books. This class of readers, the writer

thinks, is one "which usually meets with too little sympathy." It is well adapted for the purpose intended, and will no doubt prove to many a useful aid in acquiring the first elements of a sound knowledge of practical medicine.

Books and Pamphlets Received.

THE GENERAL PRACTITIONER'S GUIDE TO DISEASES AND INJURIES OF THE EYE AND EYELIDS. By Louis H. Tosswill, B.A., M.B., Cantab, &c. London: J. & A. Churchill.

ELEMENTARY PRINCIPLES OF ELECTRO-THERAPEUTICS FOR THE USE OF PHYSICIANS AND STUDENTS. Prepared by C. M. Haynes, M.D. Chicago: McIntosh Galvanic and Faradic Co.

CLINICAL LECTURES ON MENTAL DISEASES. By T. S. Clouston, M.D. With an abstract of the American Statutes by Charles F. Folsom, M.D. Philadelphia: Henry C. Lea's Son & Co.

DIAGNOSIS AND TREATMENT OF DISEASES OF THE HEART. By Constantin Paul. Translated from the French. New York: Wm. Wood & Co.

PRACTICAL MANUAL OF OBSTETRICS. By Dr. L. Kerrier. Fourth edition. Enlarged and Revised. With notes by Edward L. Partridge, M.D. New York: Wm. Wood & Co.

HOOPER'S VADE MECUM. Tenth edition; revised by Wm. Augustus Gray, M.B., and John Harley, M.D. Vol. I. New York: Wm. Wood & Co.

THE PATHOLOGY, DIAGNOSIS AND TREATMENT OF THE RECTUM AND ANUS. By Charles B. Kelsey, M.D. New York: Wm. Wood & Co.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, March 28th, 1884.

T. A. RODGER, M.D., PRESIDENT, IN THE CHAIR.

Fracture of the Femur.—The following is an abstract of a paper read by Dr. Jas. Bell on "Some Cases of Fracture of the Femur, treated by plaster-of-paris splint." Three cases were reported, all occurring in children.

The first, a little boy 1½ years of age, with simple fracture in the middle third. The second, a boy four years of age, with fracture just below the trochanter from direct violence,—being run over by a heavily-laden cart.

The third case was that of a strong, healthy boy, aged 8 years, with fracture at the junction of the upper and middle thirds. In all these cases the treatment was the same. Ether was given,

the limb extended, and the fragments brought into position, and held there until a plaster splint had been applied, extending from the toes and including the pelvis and loins. Coaptation splints of pasteboard were moulded to the leg and applied between the layers of plaster bandage.

In none of these cases has there been the slightest trouble of any kind, and in each case when the plaster was removed the union was found to be most satisfactory. In the first case there was no appreciable shortening. In the second about a quarter of an inch, and in the third a little over a quarter, but less than half, an inch. These cases were exhibited, as also an old man aged 62 years who had a bad compound fracture of both tibia and fibula just above the ankle joint. The fracture of the tibia had been oblique and about three-quarters of an inch of the protruding fragment had to be removed with the saw before it could be reduced. The limb was then permanently fixed with plaster-of-paris, leaving the wound exposed through the small opening in the bandage. The wound was dressed with Listerian precautions and the patient was discharged at the end of eight weeks with a sound leg. He is now doing his regular work (six months after recovery), and has been for some time, without any inconvenience. The writer, in summing up, thought that in a great many cases the plaster-of-paris splint was the best that could be applied to a fractured femur, notably in children, in nervous and fidgeting people and in fractures complicated with delirium tremens, also among the poorer class of patients, where a suitable bed and good nursing (which are so essential in the ordinary treatment of extension) could not be secured. He also thought that the objections urged against it for fracture of the femur were very much overrated.

Dr. Gurd said that he would not like to risk treating an adult's fractured femur in this way, as he feared that before union had occurred there would be no pressure around the limb, owing to the rapid atrophy which follows disuse and bandaging, thus allowing displacement of the fractured ends.

Dr. Blackader said he had broken the femur of an infant with the blunt hook in a difficult breech case and, assisted by

Dr. Sutherland, a gutta percha splint was applied, which answered admirably. Dr. Sutherland said he was going to use plaster-of-paris splints in these cases in the future.

DR. SHEPHERD quoted Heath as saying that there was no necessity to take in the joints where plaster-of-paris was employed.

DR. RODGER had lately used plaster-of-paris splint for fracture of the femur in a child aged 5 years with excellent results. He always uses this method of treatment for fractures of tibia and fibula.

Cases in Practice.—DR. BELL said that this evening he had been sent for by the Coroner to make a post-mortem examination on a young man, aged 28, who had been found dead in his bed. Death was found to have been caused by the bursting of a small aneurism into the pericardium. The aneurism arose from the lower and back part of the tranverse portion of the arch. The young man had been treated as an out-door patient at the Hospital for pains in the back. Aneurism had not been detected.

Stated Meeting, April 11th, 1884.

T. A. RODGER, M.D., PRESIDENT, IN THE CHAIR.

DR. TRENHOLME exhibited *two pairs of Ovaries and Tubes* lately removed. One case was operated on 22nd March. Both ovaries were much diseased and enlarged to about four times their normal size. The patient was 32 years old, and had always suffered much at her monthly periods. Her sufferings have gradually increased year after year up to about November last, when she began to manifest symptoms of insanity of a melancholy religious character, with a suicidal tendency. Her monthly sufferings abated with the advent of the mental infirmity. The patient had been under the care of Dr. M. in Ontario, who suspected some disease of the internal organs of generation and sent her down to Dr. T. On examination both ovaries were found to be enlarged and tender, the uterus congested, and tender, but otherwise normal. The operation was mad[redacted]

with the hope of benefiting her mental condition. The wound healed by first intention throughout, and the sutures were removed on the 5th day, not a drop of pus being present. The patient made a rapid recovery, and returned to her home before the end of the third week. But little could be determined as to the result of operation upon her mind, but, so far as could be judged, she seemed somewhat benefited. The future of this patient will be watched with interest and reported to this society at another time.

Case 2.—Patient, aged 22, has suffered much for several years from pelvic pains, aggravated at each menstrual period. Both ovaries tender and enlarged, uterus congested and very tender and also retroverted. Attempts at replacement and the use of a pessary had been followed by pelvic cellulitis; even with greatest care could not tolerate a pessary. Rest and local treatment relieved for a time, but when she attempted to work was again laid up. As the girl had no friends or means of support, and her health precluded service I removed the specimens now before the Society. Both ovaries (as you see) are much enlarged, undergoing cystic changes. The tubes also very much congested. This patient has so far made a most unsatisfactory progress towards recovery. There seem to be no healing powers in her, and, while no dangerous symptoms threaten life, a tedious convalescence is looked for.

DR. HY. HOWARD considered the first to be a case of acute dementia, and said that peripheral irritation, especially from the organs of generation, will some times be followed by dementia in both sexes, often taking the form of religious dementia. Dr. H. mentioned two or three cases where young men on the first night of their marriage became insane.

Purpura Hæmorrhagica.—DR. KENNEDY mentioned that lately he had had under his care four cases of this disease, all in young children of different families. He asked if other members had seen an unusual number of those cases.

DR. REED said he had been treating one case at the Dispensary.

Nitroglycerine in Epilepsy.—DR. F. W. CAMPBELL spoke of the continual good results he is having with nitroglycerine in the treatment of epilepsy. None of the patients whom he has so treated have been entirely cured, but with all the attacks are milder and much less frequent. The usual dose which he gives is one drop of a one per cent. solution three times a day.

DR. TRENHOLME asked for the modus operandi of this treatment.

DR. CAMPBELL said that it was not easy to say how it acted; but if it is true, as some authorities affirm, that with epileptics there is anæmia of the brain from contraction of its arteries, then we can see how the nitroglycerine is useful, knowing, as we do, its action in dilating the blood-vessels of the head, as does smelling nitrite of amyl.

DR. HY. HOWARD congratulated Dr. Campbell on his success in this treatment of epilepsy and said that the Germans classified the forms of epilepsy as follows:—1st, Those due to contraction of the cerebral vessels from irritation to the vaso-motor nerves. Here bromide of potassium is very useful. 2nd, An abnormal condition of dura mater. Bromide useless. 3rd, Due to irritation of the anterior pillars of the spinal marrow. Ether spray best for this. 4th, Lesions of different parts of the brain or cord. Of course the difficulty is to be sure of the cause.

ONTARIO MEDICAL ASSOCIATION.

FOURTH ANNUAL MEETING.

This society met this year in Hamilton, in the City Hall, the Council Chamber being used for the meetings. The attendance of members throughout was very good, though not many were present from the eastern parts of the province.

The first session opened on Wednesday morning, June 4th, with a very good attendance—the President, Dr. Daniel Clarke, Toronto, in the chair. After the reading and confirming of the minutes, various communications were presented and read, amongst them a letter of regret from Dr. Fenwick, Montreal, at his inability to accept the invitation to be present as a guest

of the association. A communication was also read from the Women's Christian Temperance Union, which was referred for consideration to a special committee. Reports of some committees having been received, it was decided to postpone the reception of the President's address till the afternoon session and in the meanwhile proceed with the reading of papers.

The only paper read during the morning session was by Dr. Workman, on "*Aphasia.*" This hale and hearty old member of the profession met with a very enthusiastic reception on his first appearance in the room, while his paper was listened to with much attention and interest. In beginning his paper he referred to the one read by him on the same subject last year, and complained that no discussion took place on it. After treating of the different theories on the subject of Aphasia, and the different varieties, he called attention to that variety which is often seen in lunatics where they are only capable of using interjectional remarks, on the cessation of which they relapse into mutism. He then proceeded as follows:—"Might we not charitably infer that something analogous to this direst condition exists in the brains of persons addicted to the senseless habit of profane swearing, who fill up with interjectional expletives those linguistic vacancies which their intellectual poverty renders them incapable of otherwise fitly tenanting? Imperatively and utterly to suppress the profane objurgations of these persons would be nothing short of reducing them to amnesic aphasia. Pass through the odoriferous knots of the great and the little unwashed, who ornament our street corners on Sunday evenings, or hearken, however reluctantly, to the silly twaddle of a string of our dandy promenaders, and then tell us how the poor creatures could contrive to escape profound mutism if deprived of their connecting linguistic links. One might as well expect to construct a wall of rough blocks without mortar. Men of good sense and cultivated minds do not swear because they have no room for oaths in their discourse. Be considerate then towards the poverty-stricken bipeds." This year a brisk discussion took place on the subject, and a vote of thanks was passed to Dr. Workman, with a request for publication.

The afternoon session was opened by the delivery of the President's address. The principal points touched on, after expressing his thanks for the honour conferred upon him, were, first, the improvements in educational matters during the last twenty-five years; then he took up the subject of specialties, pointing out the absurdities of dividing up the subjects of medical practice. After that he spoke at some length on the matter of advertisements in the press, both secular and religious, many of which by their insinuations, he considered, did so much harm; as also the advertisers who pretended to be so anxious for the welfare of their brethren. He also alluded to what he called the alphabetical advertisers and their advertisements, giving accounts of wonderful cases they cured. Finally the address spoke of the proper attitude of medical men towards the public and one another.

Dr. Howe, of Buffalo, delegate from the New York State Medical Association, was then introduced, and took a seat on the platform. The former presidents, all of whom were at the meeting, were also invited to seats on the platform.

The next paper read was by Dr. Tye of Chatham, "*On the Management of the Third Stage of Labor*," he being opposed to the employment of Dr. Credé's method entirely, but rather favoring a modification, and waiting, rather than express the placenta, so as to enable expulsion on the part of the uterus alone. Considerable discussion ensued, the general opinion apparently being opposed to too hasty expulsion, but some speakers thought Credé's method had been rather mis-stated.

Dr. Powell of Edgar then read a paper "*On Later Antiseptics in Private Practice*," showing, in illustration, a very handy arrangement for irrigation made by taking an ordinary beer bottle, punching out the bottom, while an indiarubber tube was attached to the cork, and the bottle slung up by the bottom. A more convenient one he considered, though, was made by substituting a long indiarubber tube for the ordinary delivery tube of a Davidson's syringe. While the tube placed in the injecting fluid was weighted or exhausting by means of the bulb in the centre, the whole apparatus was converted into a syphon,

and any vessel could be used for the irrigating fluid. He also exhibited specimens of various antiseptics now employed, such as peat, wood-wool, punk, iodoform and various kinds of prepared gauze, also decalcified bone drainage-tubes. He spoke strongly in favor of the use of bichloride of mercury solution applied locally.

Dr. Griffin of Brantford then gave the history of a case of *Tumor in the Abdomen* which caused obstruction of the bowels, great pain being experienced and local swelling found. On *post-mortem* examination, the cæcum was found to admit only a No. 4 catheter. The specimen was shown to the meeting.

Dr. Brouse of Brockville read a short paper giving an account of two cases of *Strangulated Hernia* operated upon by him, and also of a successful *ovariotomy*, in which, on opening the peritoneum, a quantity of syrupy fluid was found, but no opening in the cyst wall, which, however, was very thin. The operation was performed under strict antiseptic precautions, with the exception of the use of the spray.

In the evening session, the first paper was by Dr. Burnham, Toronto, "*On the use of Carbolic Acid in Purulent Affections of the Eye*," a remedy whose value was rather disputed by those taking part in the subsequent discussion.

Dr. Thorburn, Toronto, then gave an account of a case of *Injury to the Spine*. The patient, while bathing, dived into water that was too shallow, and was noticed floating on his face, and when rescued, his spine was found to be injured, there being complete loss of power of the lower extremities. The spine was extended, and the patient lived 24 days, during which he apparently enjoyed life to a great extent, as he eat, smoked, and felt quite free from anxiety, though occasionally suffering pain. On making a *post-mortem* examination, it was found that there had been a dislocation of the fourth cervical vertebra, which was fractured and the spinal cord compressed. The vertebræ were shown to the meeting, and also a sketch of the spinal column and cord. Considerable discussion followed, and several cases were mentioned, amongst others, one by Dr. Workman, who gave the history of a case that lived four weeks; Dr. Hunt of Clarks-

burgh, one that lived a year; Dr. McCargow of Hamilton, who had had seven cases, one of which lived a year; and Dr. Brown of Galt spoke of the case of a patient who, after recovering apparently from an injury to the spine, about a year afterwards showed signs of diabetes, and eventually died of it.

The next paper was one read by Dr. Adam Wright, Toronto, "*On the Prevention of Puerperal Fever*," a very able and well written paper. One point which he considered of great importance was the state of the mind, many cases, in his opinion, being due to excitement on the part of the patient, instances being given where, on removing any cause which tended to excite the patient, recovery from the fever was very speedy, and with a view to calming the patient's mind, he was therefore opposed to the idea that a labor should be viewed in the light of a capital operation. Another point upon which he laid great stress was the use of injections, which he considered unadvisable as a matter of routine: also, the use of pessaries, as tending to diminish the lubricating secretions. He advised, therefore, that the patient should make water in the knee-elbow position, as by this method small clots were enabled to escape from the uterus and vagina.

On the conclusion of Dr. Wright's paper, J. J. Mason, Esq., Mayor of Hamilton, one of the invited guests of the Association, was introduced to the meeting, and delivered a short address of welcome, in which he expressed the hope that the visit of the Association might be profitable to the members, and that it might not be the last. He also remarked that he took more interest in the proceedings than might be expected, because he was the son of a physician—Dr. Mason of Brantford.

The discussion on Dr. Wright's paper was then proceeded with, and was generally participated in, there being a good deal said, though, that had little bearing on the subject of the paper, so the President called the members to order, and Dr. Wright having replied, the discussion closed.

The last paper was read by Dr. Turver, of Parkdale, on *Uterine Displacements*, which he illustrated by a pessary that he used in anteflexions and prolapses. The pessary was a

lever, with rubber pad or apron, as the inventor called it, over the front part, intended to receive the anterior part of the cervix and prevent erosion. Several cases which had been successfully treated by this instrument were related, and some questions put by different members were replied to, and the meeting then adjourned.

On Thursday morning communications were read from Mr. Boxer, of Montreal, and Dr. Playter, of Ottawa, and their consideration postponed.

Dr. Graham then read a paper giving an account of several cases of *Idiopathic Anæmia*. He ascribed the origin of the disease to the nervous system, and with regard to treatment, preferred arsenic in the form of Fowler's solution. In the succeeding discussion Dr. Cameron, Cayuga, expressed the opinion that the disease was analogous to scorbutus as so many cases were seen amongst farmers, and especially in winter, when vegetable diet was scanty. Dr. Sheard, Toronto, considered it an error to ascribe all obscure diseases to the nervous system, but thought there might be possibly an abnormal condition such as would produce the changes found in the blood corpuscles. Dr. Arnott, London, inquired as to the value of eucalyptus, as he had derived great satisfaction from the use of it.

Dr. Groves, of Fergus, read the next paper, which was on the *Operative Treatment of Purulent Effusions into the Chest.* The trocar which he used was shown, the principle being that the trocar drew back in the canula till an opening was exposed in a short neck to which an india-rubber tube was attached for the injection of fluids. Dr. Groves favoured making two openings in the chest wall, while others who spoke, favoured the syphon principle and used only one, Dr. Powell, of Edgar, showing how he retained the tube which he used, an Esmarch's bandage being employed. Dr. Hutchinson, of Brussels, followed with the history of a case of *Hodgkin's Disease* in a girl aged ten, the left cervical glands being especially affected. The patient was shown to the meeting.

Dr. Worthington, of Clinton, then read a paper on "*Cerebro-Spinal Meningitis*," giving an account of the epidemic of

1871-72, as seen in the county of Huron, near Clinton, the treatment he found most successful being by aconite and morphine. Drs. Harrison, of Selkirk, and McCargow, formerly of Caledonia, spoke of cases seen by them during the same epidemic, as did also Dr. Campbell, of Seaforth. The afternoon session was opened by the exhibition of patients, Dr. Alexander, of Grimsby, showing a man with great enlargement of the lower third of the right femur which was very hard while the knee was very weak and bent inwards on standing or walking, the condition of the knee dated from an injury two years ago followed by another a year later. Dr. Osborne, of St. George, showed a woman with a growth in the left inner canaliculus that had been at first pustular, but afterwards became more tubercular, its duration being about 7 years.

The following resolution was then moved by Dr. Powell, of Edgar, and seconded by Dr. Fulton, of Toronto, and carried, "That the President for next year be requested in appointing the chairmen of the temporary committees to select gentlemen with whom he has previously made arrangements for the opening of discussions on special subjects in their departments. Each discussion to be opened by the reading of a paper by the chairman, which paper shall take the place of the reports heretofore expected."

Dr. Rosebrugh, of Toronto, read a paper on "*Boracic Acid and Boro-glyceride*," in the Treatment of Purulent Inflammation of the Middle Ear. After speaking of the necessity of antiseptic treatment in these cases as a long recognized fact and the objections made to them, he spoke of Boracic acid and the objections to it. Then he described the preparation of Boro-glyceride and its method of use. At first he employs a 50 per cent. solution and then gradually diminishes the strength of the solution, great care being taken to thoroughly cleanse both the internal auditory canal and the middle ear before the boro-glyceride is applied. By the use of this remedy he claimed that the treatment was greatly shortened, only taking three or four weeks, where it formerly took as many months. At the close of the paper it was shown that boracic acid floats on the surface of water, thus distinguishing it from borax, which sinks at once

Dr. Harrison, of Selkirk, then read a paper on "*Vaccination*," in which he very ably and in his usual witty style answered the charges of the anti-vaccinationists. During the discussion which followed, Dr. Bryce, Secretary of the Provincial Board of Health, spoke of the difficulties experienced in getting proper vaccine to supply the profession.

Dr. Riordan, Toronto, described a case in which there was a septum completely dividing the vagina into two compartments while the uterus was also double. Dr. Brown, of Galt, read an account of cases seen by him in Edinburgh and London, and Dr. W. H. B. Aikins read a paper on the local treatment of Spermatorrhœa. The various reports of committees were received and that on Medical Ethics referred to the next meeting to consider at an early stage.

The committee on the questions put by the Women'sChristian Temperance Union reported that some had only a social bearing while the others were too important for the committee to consider, so were left to the next meeting of the society.

The report of the nominating committee was received and adopted, the following officers being elected: *President*—Dr. Worthington, Clinton. *1st Vice-President*—Dr. Tye, Chatham. *2nd Vice-President*—Dr. Richardson, Toronto. *3rd Vice-President*—Dr. Brouse, Brockville. *4th Vice-President*—Dr. Powell, Edgar. *General Secretary*—Dr. J. E. White, Toronto. *Treasurer*—Dr. J. E. Graham, Toronto. *Corresponding-Secretaries*—Dr. Irwin, Kingston; Dr. Harris, Brantford; Dr. Waters, Coburg; Dr. Hutchinson, Brussels.

The next meeting to be at London. As no communications or papers had been presented on the subject of *Bacteria*, a special committee on Bacteriology was appointed. The question of a Provincial Medical and Surgical Museum was referred to a committee consisting of Drs. Clarke, Worthington and White to confer with the Ontario Medical Council and Government. The usual votes of thanks having been passed, the meeting adjourned at 6.45 p.m. Although no public entertainments were given, the Association not wishing anything of the kind, a large amount of private hospitality was dispensed, and all seemed well satisfied with the proceedings.

CANADA

Medical and Surgical Journal.

MONTREAL, JUNE, 1884.

CONTAGIOUS DISEASES AND TRAVELLING.

The isolation of a person the subject of a contagious malady, for the purpose of protecting a community from the contagion is clearly founded upon the plainest common sense. Real—strict—isolation it is often difficult to secure, but it should certainly always be the aim of sanitary authorities to prevent the exposure of those under their care to any contagion as far as this can be accomplished. It is plainly a grievous moral wrong for any person who knows himself to be afflicted with a contagious disease to travel by public conveyances, where a number of unsuspecting persons are liable to suffer from his proximity. It is also as plainly the duty of every medical man to point out to any one thus diseased the injury he would be inflicting upon his fellow-passengers. What therefore can be said of medical men who would knowingly aid and abet persons laboring under the most alarming contagious diseases we know of to procure passage by rail and in cars occupied by numbers of other persons? Surely their guilt is great. Such occurrences as we have alluded to are fortunately rare, but within a few weeks of each other glaring examples of the transportation of small-pox in the one case and diphtheria in the other have been brought to light in this country. The former happened in Ontario and the latter in this city. The facts of the Ontario case have recently been substantiated at the trial of the offending parties. It appears that Dr. Whitely, of Goderich, drove one Little, who was suffering from small-pox, in his buggy and set him down 150 yards from the station. Little was going, on the doctor's

advice, to London. At Clinton, his disease having become known, Little was locked into an empty baggage-car by himself and taken to the small-pox hospital at London where he was cared for. Great indignation was everywhere expressed and actions were taken against Little and Dr. Whitely; both were convicted of the misdemeanour and the former suffered a nominal imprisonment and the doctor was fined $20, the judge remarking that he was lenient in consideration of the youth of the accused. The Montreal case was as follows: A woman, from the Eastern States, was on a visit to friends in a country district about 60 miles from this city, accompanied by three children. Two of these showed symptoms of diphtheria of a severe type. On the third day of the illness, the mother states, she was advised by the local practitioner to take them by rail to Montreal, receiving orders not to tell anybody what was the matter with them. This she did, and arriving here put up for the night at a hotel. The following day the sick children were taken into the Montreal General Hospital. At this time the worst case of the two was in a lamentable condition—glands greatly swollen, mouth open, abundant running from the nose, intense fœtor of the breath, laryngeal symptoms already showing themselves, and he rapidly sank and died next day. The other child recovered. What action was taken in this case? None that we know of. The matter was made public through the papers and must have been reported to the sanitary authorities, but no pains were taken (as far as our information goes) either to sift the facts, to disinfect the premises occupied, to punish the guilty, or enforce a lesson upon the community. There is a degree of apathy hereabouts concerning contagious disease that is very remarkable. There is a good deal of talk about preventive measures, and so forth, but the inactivity displayed in this instance shows how easily foci of these communicable affections can be established here and how certain these are not to be stamped out in the beginning.

THE CONSTITUTIONAL TREATMENT OF TUBERCULOSIS OF JOINTS.

During the last four or five years there has been an evident change in professional opinion as to the part played by constitutional conditions in general, in causing and shaping many of the more common chronic diseases of joints. The prominent part taken by tuberculosis in originating disease of the articular structures of bone has, it may be said, only been recognized by surgeons within the last three years. Even yet there are a few who consider that injuries are the sole cause of such diseases as the ordinary chronic hip disease of childhood. Prominent among the supporters of this one-sided view is Sayre of New York. He goes so far as to maintain that hip joint disease is always of traumatic origin, and that constitutional conditions like tuberculosis have no part in the origination of the disease.

We remember that this view of Sayre was stoutly maintained by a prominent Canadian surgeon who read a paper on chronic joint disease at the meeting of the Canada Medical Association, held in Hamilton in 1878. In the discussion which followed the reading of this paper Dr. R. P. Howard eloquently and forcibly urged the necessity of taking a more comprehensive view of the causation of these cases. He showed how much *tuberculosis*, and how little *traumatism* had to do with cases of chronic joint disease.

The views on this subject urged by Dr. Howard seven years ago, are if we mistake not, the views almost universally adopted by the prominent surgeons of the day. It is particularly in Germany that the important part played by tuberculosis is now recognized by surgeons.

The tuberculous infiltration takes place, not in the soft structures of the joint as a rule, but in the articular extremity of the bone, the soft structures becoming secondarily affected. There is great similarity in the way in which tubercle affects the lungs and bones. In the case of the former the infiltration nearly always takes place into the lung texture, the pleura becoming only secondarily involved. In the case of the bone the cancel-

lous structure is not unlike the tissues of the lungs and the synovial membrane bears a somewhat similar relation to the cancellous structure as does the pleura to the lungs. Primary tuberculosis of the synovial membrane is as rare as primary tuberculosis of the pleura.

It is important when dealing with the management of chronic joint diseases, not only to know that tuberculosis is an important factor in their condition, but also it is important to know that the disease begins in the hard structures and not in the soft structures of the joint. It is not the intention here to refer to the local treatment of these cases, but to make mention of the importance of not neglecting general measures.

No doubt, when the tuberculous nature of many cases of hip joint diseases is recognized, excision will be more generally performed than it is, but on this subject and the equally interesting and important one of the so-called "anti-tuberculous properties" of iodoform we will not now enter. At present reference will only be made to the general treatment of joint tuberculosis by means of arsenic.

Langenbeck, a few weeks ago, gave an account before the Berlin Medical Society of six cases of tuberculosis of joints treated with arsenic after excision had been performed. Three of the cases were where the elbow joint was resected, one where the hip joint was resected, and in the two remaining cases the knee joint had been removed. All on account of tuberculosis. The details of only one case are published up to the present. It was that of a child aged 8, who was brought to Langenbeck last December, with inflammation of the left hip joint of a year and a half standing. The child was very much reduced and had almost constantly considerable elevation of temperature. The region over the left hip joint was greatly swollen, and so sensitive that the examination had to be made under chloroform. The joint was immediately excised. The head of the femur was in part destroyed and dislocated. The resection was made beneath the level of the trochanter. The acetabulum was so infiltrated that it had to be perforated, and a portion of it in all its depth removed. The granulations on

the remaining soft structures were carefully scraped away. The large cavity left was carefully irrigated with corrosive sublimate (1 to 1000). Two drainage tubes were inserted, the lips of the wound were brought together and covered with iodoform gauze, slight extension was put on the limb. For a few days the state of the patient was very favorable, the temperature became normal, and there was freedom from pain. After eight days, however, the temperature commenced to rise in the evenings, and the wound to pour out a large quantity of pus. The already almost healed wound was laid open, and the copious discharge of pus soon reduced the patient's strength so much that nothing but a fatal issue was looked forward to. The temperature varied from 100° in the mornings to 104° in the evenings. Quinine and other agents, including cod liver oil, had no effect in allaying any of the symptoms. Arsenic was now given, at first in doses of one drop and after a few days two drops of Fowler's solution. After fourteen days of the arsenical treatment the condition of the child changed wonderfully. The temperature fell to normal, and the appetite improved rapidly. The wound commenced to heal and in the course of four weeks it had become superficial. The general state of the child had quickly undergone a wonderful change from an apparently hopeless condition to one of considerable vigor. In Langenbeck's remaining five cases results similar, and almost as striking, as the one related, occurred.

The results obtained by Langenbeck are certainly very striking and demand the serious attention of all those who have to do with the treatment of such cases. It is idle speculating as to the way in which it can possibly act for good in these cases. It appears improbable that the good effects can be attributed to the marked hæmatinic properties which we know it does possess.

In a future number we intend making reference to the action of arsenic in lymphomatous tumors. There has quite recently been published evidence of this action of such a nature as to leave no room for doubt but that we have in arsenic an agent that is capable of curing many of these cases.

Medical Items.

—The ashes of Prof. S. D. Gross weighed about seven pounds. They were enclosed in a marble urn about three feet high, unornamented and without inscription, and placed beside the coffin of his late wife in the family vault at Woodland Cemetery.

MATERNAL FOUNTS.—There is living in Montijo a woman with four mammary glands; two are situated in their ordinary place, and the other two, a little smaller, perpendicularly and two centimetres above, one on each side, with their corresponding nipple. She is at present nursing a child with the four breasts, all having an abundance of milk. (*Il Siglo.*)

ANTISEPTIC ABSORBENT SPONGE.—Mr. Sampson Gamgee showed before the Medical Society of London, April 21st, an artificial antiseptic sponge of his invention. A small capsule, containing eucalyptus or other antiseptic, was enclosed in absorbent cotton; outside of this was a layer of cocoanut fibre, and outside of this more absorbent cotton-wool; the whole being enclosed in gauze. When about to be used the capsule could be broken by a blow of the fist, and the absorbent cotton became permeated with the antiseptic. He said these sponges could be made at a very trifling cost, and hoped they would come into use as a cheap substitute for ordinary sponges; they possessed this great advantage, that when required for use they were certain—however long they might have been kept—to be antiseptic: and, being so cheap, they might always be destroyed after being used.

VASELINE.—Amongst all the new preparations of petroleum, vaseline, the original form of petroleum jelly, still holds its own. Its perfectly stable qualities, its resistance to all putrefactive changes, renders it pre-eminently suitable for use as the basis of numerous ointments. Its soft and emollient nature at the same time indicates it as the most appropriate agent for all soothing applications requisite for tender surfaces, such as the nares, the eyes, &c. Much as the standard is used, it deserves, from its many good qualities, still more extensive employment.

CANADA

MEDICAL & SURGICAL JOURNAL

JULY, 1884.

Original Communications.

ABSTRACT OF A CLINICAL LECTURE ON A CASE OF EXOPHTHALMIC GOITRE.*

By JAMES STEWART, M.D.,

Professor of Materia Medica and Therapeutics, McGill University; Physician to the Montreal Dispensary, and Director of the University Dispensary for Diseases of the Nervous System.

Gentlemen,—The patient whom I exhibit to-day presents a marked example of exophthalmic goitre, or what is more commonly called Graves-Basedow disease. It is an affection usually described as exhibiting three symptoms. These are exophthalmos, goitre, and increased cardiac action. As we, however, proceed in the investigation of this man's case, we will find that, in addition to the above classical symptoms, there are present others equally as prominent and equally as important.

The patient, aged 31 years, lumberman, complains of great weakness, with palpitation of the heart and shortness of breath on the slightest exertion. He first noticed these symptoms three years ago. He says that he rapidly became thin and weak, and was, in consequence, compelled to give up his work. It was some time—probably six months—before his people remarked that his eyeballs were prominent. He cannot remember when his neck commenced to enlarge. He had syphilis six years ago. In following his occupation he has been exposed to great hardships. There is nothing to be learnt from his family history.

* This lecture was one of the usual clinics on nervous cases conducted during the present summer session of McGill University. The patient was very kindly handed over to me for clinical uses and treatment by Dr. Reid.

As far as can be made out, it is not a neurotic one. He is, as you will easily observe, anæmic and emaciated. He is excitable, irritable, suspicious, and at times very despondent. He complains of severe frontal headaches at times. He is frequently troubled with sleeplessness. The prominence of the eyeballs is very marked, a rim of the sclerotic being clearly discernible all around the globes of the eyes, giving to them a peculiar lustre. The pupils are normal in size. What is now commonly known as Graefe's symptom is not present in this case—that is, the movements of the eyeballs and upper lids are not consentaneous. The lids follow the movements of the globe. It is said that Garefe's symptom is almost constantly present in this disease. It is due to the paretic condition of the involuntary muscular fibres (Müller's) in the lids. There is considerable enlargement of both lobes of the thyroid glands, but especially of the right one. This enlargement, the patient says, varies greatly from day to day and from hour to hour. The thyroid vessels are very numerous and dilated. There is marked pulsation in the gland, which is clearly perceived at a distance of several feet. A systolic blowing murmur is heard on laying the stethescope over the enlarged gland. There is marked pulsation over all the cardiac region, and on laying the hand over the same parts a marked systolic thrill is felt. The apex of the heart is displaced downwards and outwards. There is a loud blowing systolic murmur heard over all the cardiac area, with its maximum intensity at the junction of the third left costal cartilage with the sternum. The transverse cardiac dullness extends from the right edge of the sternum to half an inch outside the left nipple line, a distance of 4½ inches. The vertical dullness commences at the upper border of the third rib. We have here positive evidence of considerable enlargement of the heart, together with, in all probability, regurgitation through the mitral orifice. This regurgitation is no doubt due to simple dilatation of the orifice, and is therefore what is known as "curable regurgitation." There are no grounds for believing that there is any structural defect in any of the orifices. His pulse is 130. Slight exertion is sufficient to send it up to 160, and sometimes even higher.

Our patient presents all the marked symptoms of the disease—the protrusion of the eyeballs, the enlargement of the thyroid, and the increased pulse rate. All cases of exophthalmic goitre do not exhibit these three symptoms. The exophthalmos or the goitre may be absent, but I believe it is generally admitted that the quickened pulse is always present—that it is, in fact, an essential factor of the disease. A fourth prominent symptom in this case is trembling of the voluntary muscles, especially when the patient makes any exertion. Sometimes it is confined to the arms alone, but more frequently it affects all the voluntary muscles. In your text-books you will find scarcely a reference to tremor as being present in this disease. It is, however, in the great majority of cases, as constant in its appearance as either the exopthalmos or goitre. Not infrequently it is so marked and troublesome a symptom as to attract the patient's attention, to the exclusion of all the other symptoms. Less frequently it may be necessary to make the patient perform some muscular movements before it can be demonstrated. This tremor, studied by the aid of a myographic drum, furnishes a tracing* which is said to be characteristic, and enables a diagnosis to be made from other forms of trembling. The number of oscillations vary from eight to nine per second; while in paralysis agitans the number is only five per second.

We know nothing about the cause of the tremblings which form so prominent a feature in many cases of this disease. Charcot was the first to direct attention to them.

Another not uncommon symptom of exophthalmic goitre is is paroxysmal diarrhœa. In this man's case it has been troublesome for the last two years. He has an excessive appetite. He complains of a frequent cough, but which is not attended by any expectoration. Repeated examinations of the urine before and after meals fails to discover the presence of either sugar or albumen. He has paroxysmal polyuria.

These are the symptoms of the case, and there is no doubt

* A tracing taken of the trembling of the hands in this case showed the vertical oscillation gradually increasing in extent, then regularly decreasing, thus presenting a fusiform aspect. It was through the kindness of Dr. Wilkins, in placing at my disposal his extensive physiological apparatus and assisting me with his advice, that I have been enabled to take a tracing of the tremor.

whatever but we have to do with a well-marked example of exophthalmic goitre, or Graves-Basedow's disease. In addition to the three so-called classical symptoms, we have tremor, paroxysmal diarrhœa, cough without expectoration, and certain psychical symptoms, all of which. especially the first named, are almost constant in their appearance in this disease. Ever since the disease was described by Graves and Basedow, there has been considerable discrepancy of opinion as to its nature. Most of the text-books of the present day in which the subject is treated contain statements which would lead you to infer that the disease is essentially one of the cervical sympathetic and its ganglia. The evidence of its being a disease of this nerve, however, is very far from conclusive. In fact, it may be said that those who have closely investigated these points are of the opinion that the disease is not one of the sympathetic nerve. Although, in a few of the recorded cases, changes have been found *post-mortem* in the cervical sympathetic and its ganglia, there has been no constant relation between the severity of the symptoms present during life and the extent of the changes after death. Again, in a number of well-marked cases, no changes have been found in the sympathetic by such competent observers as Recklinghausen, Wilks, Paul, Ranvier and Ross. From this it certainly follows that there is not pathological evidence to support the view that the disease is one of the cervical sympathetic. Neither do physiological considerations or clinical facts give support to this view of the nature of the trouble.

To explain the dilated condition of the thyroid vessels, a paresis of the vaso-motor fibres running in the cervical sympathetic has been assumed, and to account for the increased rate of the heart irritation of the accelerator fibres in the same nerves. It is thought that the one and the same lesion is capable of bringing about two directly opposite effects, viz., paralysis of one set of fibres and irritation of another set. This is, of course, highly improbable, but what is still more so is, that a certain set of fibres should remain in a state of irritation for many years without any indications of paralysis. If any further proof were needed to show the inadequacy of changes in the sympathetic

as being the cause and origin of this disease, it would be found in the absence of pupillary changes. It is not conceivable that either partial or complete destruction of the sympathetic should not be followed by changes in the size of the pupil. Now it is a well known fact that pupillary changes are not present in this disease. The evidence just given, although of a negative character, is of sufficient weight to make us at least suspect that the central nervous system is the true seat of the changes that give rise to this disease. We, however, have facts of a positive character which go a long way to prove that it is in this part of the nervous system that we must look for its origin. Filehne has produced protrusion of the eyeballs, enlargement of the thyroid gland, and increased action of the heart in rabbits by wounding the restiform bodies. I am not aware that there has been any microscopical examination of this portion of the medulla, or, in fact, of any part of the medulla, in persons dead from Graves' disease. Whether changes will be found or not, it is, of course, impossible to say. The rather frequent occurrence of glycosuria and even diabetes lend support to the view that the changes in the nervous system will be found (in part at least) in the medulla.

That the higher nerve centres are sometimes involved is evidenced by the fact that insanity is not an infrequent complication. In all cases there is considerable mental irritability and despondency, while at times the psychical symptoms are so marked as to constitute the most prominent part of the disease. What the nature of the changes is in the medulla and higher nerve centres is not known. That they are of a so-called "functional" nature in a great number of cases, is shown by the very frequent and complete recoveries.

The *prognosis* in exophthalmic goitre is much better than some of our modern text-books would lead you to think. By far the greatest number of cases recover. Relapses are, however, not uncommon, prolonging the disease to many months and sometimes years. Those cases attended by very marked psychical symptoms have a much more serious prognosis. It is especially bad when mental depression alternates with violent

mania, especially when the mania is of the noisy, destructive, and incoherent kind. Cases of this kind run nearly always a short and lethal course. The prognosis in this patient's case is favorable, despite the severity and long-continuance of the disease.

Treatment.—As you will readily understand, the remedies that have been recommended in this disease are not few in number. Iron, quinine, digitalis and belladonna have all been lauded as having a directly curative action. It is very questionable, however, whether any of them possess this power. Of the four, digitalis is the one that is most commonly prescribed. It has, strange as it may seem, little or no power in slowing the heart's action. Iron, even for the relief of the anæmia that is often present in this disease, seldom does good, but frequently injury. There is no drug in my experience whose action is so beneficial in exophthalmic goitre as ergot. We know that when given in large doses, ergot acts in the following way on the heart and circulation: 1st, it slows the action of the heart; 2nd, it contracts the arteries; and, 3rd, it increases the blood pressure. How it acts in this disease I am unable to say, but the first sign that is noticed of its beneficial effects is a slowing of the circulation. From a considerable experience of its use in this disease, I have found that after two or three weeks' use, a pulse that is constantly beating at 130 or 140 is brought down to from 110 to 120. As the drug is continued, the swelling of the thyroid gradually diminishes also, and the protrusion of the eyeballs gradually recedes. To obtain marked amelioration, it is necessary to give it for at least three months. I have reported* three cases of exophthalmic goitre treated by ergot, where the results were very satisfactory. In all a cure resulted. In a disease which tends in many cases to spontaneous cure, it is necessary to be very cautious in coming to a conclusion as to the virtue of any drug that may be used. Whether ergot has a directly curative power remains still to be proved. I think, however, that I am quite justified in saying that of all drugs we possess, it is the only one which seems to act with marked benefit

* *Canadian Practitioner*, Sept., 1881.

in the disease. In order, however, to obtain its full physiological power, it is useless to prescribe it in the doses given in the Br. Ph. At least one drachm of the fluid extract should be given three times daily. Even from considerably larger doses than this I have never seen any untoward effects. Galvanism is probably the most powerful means for good that we possess. It should be applied, according to Erb*, as follows: The anode should be placed over the spine between the shoulder blades, and the kathode worked along the whole of the cervical spine. From one to two minutes sittings of not more than six or eight Stohrer elements is recommended. Still weaker currents may be used directly applied to the posterior part of the head, so as directly to influence the medulla. Galvanization of the sympathetic (subaural galvanizatiou) may fulfill the symtomatic indication of slowing the circulation.

The other symptomatic indications that arise during the course of the disease require no special treatment. The alleged cure of some cases of this disease by the removal of the enlarged thyroid has led some recent observers to maintain that there are two forms of Graves' disease—one local, and due to the pressure exerted by the enlarged gland on the sympathetic, the other due to changes in the central nervous system, and that the former is curable by surgical means.

We will commence the treatment of this man's case by giving him 45 minims of the fluid extract of ergot three times daily. and gradually increase the dose until he takes a drachm or more three times daily. To prevent any misconception as to its action, we will give it alone. If, after a course of three months' treatment, there is no improvement, we will then employ galvanism.

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* Erb, *Handbuch der Elektrotherapie*, s. 596.

CLINICAL LECTURE ON THE ANTISEPTIC TREATMENT OF WOUNDS BY DRY AND INFREQUENT DRESSINGS.

DELIVERED AT THE MONTREAL GENERAL HOSPITAL JUNE 28TH, 1884,

BY FRANCIS J. SHEPHERD, M.D., C.M., M.R.C.S, ENG.,
Surgeon to the Hospital.

Gentlemen,—As you are aware, during the last few years the different methods of treating wounds antiseptically have attracted much attention in the surgical world. To Sir Joseph Lister is due the credit of having revolutionized wound treatment and rendered operations, once formidable and dangerous, comparatively safe. His method, surrounded by many forms and ceremonies, which his followers insist on even more than he does himself, was only slowly taken hold of by surgeons. Those chiefly who themselves saw the results of Lister's treatment in his own hospital practice at the Infirmary in Edinburgh adopted his mode of treatment. These disciples earnestly propagated his doctrines, and Germany was soon converted to Listerism by enthusiasts such as Nussbaum, Von Bruns, Hueter and others. From being hotbeds of erysipelas, pyæmia and septicæmia, German hospitals were transformed into veritable sanitoriums, and German surgeons became apostles of cleanliness. Where the mortality had been 50 to 75 per cent. after amputations, it fell to 5 to 10 per cent., so much did Listerism accomplish. The alteration in the mortality of London hospitals was, owing to careful and cleanly surgery, not so marked, and even Lister himself could hardly surpass the splendid results attained by the late Mr. Callender. It soon began to be asked, Why is Listerism so successful, and is there no way of attaining the same results by a simpler and less expensive method? Many maintained that the success of Listerism merely depended on the more rigid carrying out of the great principles of wound treatment, viz.: rest, pressure, cleanliness, and drainage; and that everything did not depend on keeping away germs and bacteria by means of the spray and elaborate dressings. The spray was first discarded, irrigation taking its place,—and the results were found to be much the same; then the

McIntosh was laid aside, and finally, instead of wet gauze, some absorbent and antiseptic material was applied to the part. Many surgeons, who at first were ardent Listerites became now merely antiseptic surgeons. The inspiration was no doubt owing to Lister and the new methods, which were soon introduced, were in reality merely modifications of his treatment, so the dry and infrequent form of dressing may be said to have been evolved from Listerism. Iodoform has played a considerable part in this, as, owing to its permanency and power as an antiseptic, it permitted long intervals to ensue before wounds became septic.

In England the dry and infrequent dressing of wounds was first advocated by Mr. Sampson Gampee, of Birmingham, and his published results certainly contributed not a little to direct surgeons to this form of treatment of wounds. He it was who first introduced absorbent antiseptic pads.

I, as you know, have practised the dry dressing of wounds for some time past, and have every reason to be satisfied with it. I have employed it in various ways and used many kinds of material, but the principles have remained the same throughout, viz., antisepticism, cleanliness of instruments, hands, and wound itself, drainage, the application of some antiseptic, absorbent material, kept in place by an elastic antiseptic bandage, and, last of all, infrequent dressings. In detail, the method of dressing wounds adopted by me is as follows:—

Suppose a leg has to be amputated. The part is first washed in a solution of mercuric bichloride, 1·1000; the hands also dipped in same after being well cleansed with soap and water and a nail-brush, and the instruments placed in a 1-20 solution of carbolic acid (as the bichloride spoils them) for an hour or two before; carefully cleaned sponges kept in a 1-20 solution of acid carbolic are to be used. Thus far you see the proceedings are in strict accordance with Lister's directions. After the limb has been removed, the wound is irrigated with the bichloride solution (1-1000), the vessels tied with catgut ligatures and the ends cut short. After all bleeding has stopped a little iodoform may be dusted over the wound, and then the

edges of the wounds should be brought accurately together by means of a few deep silver wire, or silk sutures, dipped in 1·40, with intermediate sutures of carbolized catgut, a drainage tube is then inserted into the most dependent part of the wound. Now comes the special form of dressing which is called "Dry." I sometimes use a layer of washed absorbent gauze and place it directly over the wound, having previously dusted it with iodoform, and also dusted the wound itself with the same material. Now is applied a square or oblong pad, such as I show you, of some antiseptic absorbent material, covered with washed absorbent gauze. This pad varies in size and shape, according to the size of limb to be encased or wound to be covered, and may be made at the time of operation. I generally dust the pad over freely with iodoform before applying it, and now place it directly on the wound instead of first putting on a layer of gauze. It is to be applied as accurately as possible, and by means of cuts made in the sides or ends of these pads they may be fitted closely to any part. The material of the pad may be of various kinds. I first used Gamgee's pad, which is of salicylic absorbent cotton wool enclosed in washed gauze, I have used peat, asbestos and oakum, but the material I prefer to all others is finely carded jute rendered antiseptic by mercuric bichloride, naphthalin or carbolic acid. It is elastic, absorbent and antiseptic. Well, the antiseptic pad having been applied, it is kept in place by an evenly and firmly applied antiseptic gauze bandage. Here I have used the ordinary carbolized gauze furnished by the Hospital, but in private practice I generally make use of a bandage of washed cheese-cloth, or book-muslin which has been rendered antiseptic by soaking in a solution of bichloride and methylated spirits, one grain to the ounce, and then, by exposing to the air and evaporating the spirit, the bandage remains charged with bichloride. In this way a very good antiseptic dressing may be made, cheaply and quickly. The dressing is now complete, the patient is placed in bed and the limb put on a pillow or swung from a cradle. If the amputation has been near a joint, as, for instance, the knee, I generally, over the gauze bandage, apply a pasteboard splint, made pliable by dipping in

hot water, and which is kept in place by another bandage. In the last amputation of the leg you saw me perform, I made use of bone drains instead of rubber, hoping by this means to do away with the necessity of taking off the dressing to remove or shorten the tubes; but in this case the tubes collapsed, being too soft, and the effused serum, being confined to the stump, caused an elevation of temperature and interfered with primary union somewhat by distending the flaps. I removed the dressings on the third day, and replaced the bone drains by rubber ones. The temperature fell immediately, and the patient from that time did well, going out in a little over three weeks.

If there is much oozing and the dressings are stained, they had better be changed on the second day, the tubes very much shortened and the dressing reapplied as before, and, as a rule, the case will now go for a week or ten days without needing change of dressing. At the next dressing, the silver wire sutures and tubes should be removed altogether, and the wound, if everything goes well, needs only one or at most two dressings more. Of course, we must be guided as to our change of dressings by the condition of the patient. If there is elevation of temperature and the patient complains of distention and pain about the wound, it should be immediately examined. I have now treated over a hundred wounds and injuries of all kinds by this method with, as you know, most satisfactory results. The method is simple and the materials used easily obtained; it is also comparatively inexpensive. Many of you, after you receive your degrees, will practice in country or other places where it will be difficult or impossible to carry out the elaborate ritual of Listerism in all its entirety; in dry dressing, however, you have a method of wound treatment that may be employed with as much success, and the materials for which may be carried in your breast pocket.

I might now call your attention to a few cases which were under treatment in my wards during last winter, and which are examples of the good results obtained by dry and infrequent dressings. Most of you remember the case of amputation of the arm for severe injury, which was in Ward 31, and

where there was primary union, the man going out cured in ten days with two dressings; also the man Hoskins, whose thigh I amputated for tumor, and in whom, with two dressings, the wound had all healed except where the drainage tubes had been. This case was a good example of the bad effect of drainage tubes left in too long, as the sinuses caused by them after the rest of the stump had completely healed were most difficult to close. Also the man Smith, in 31 Ward, whose leg I amputated for railroad injury, and who went out in three weeks with the stump healed by first intention. These were the most favorable examples, perhaps, you will say; but still they fairly show, I think, results that may be obtained by the dry dressing. This mode of treatment is suitable to all forms of wounds and injuries. You have lately seen several cases of severely crushed hands thus treated by dry and infrequent dressings with remarkably good results, and have also seen knee-joints opened and afterwards put up in this way and do exceedingly well. Abscesses also may be easily and successfully treated in the same manner. You may, perhaps, remember a case of large gluteal abscess in Ward 31 last winter, where, after opening it at the most dependent point and evacuating several pints of pus, and inserting a drain, I treated with iodoform and dry dressing, and where the progress to recovery was uninterrupted. I might here mention to you a point with regard to the after-treatment of abscesses, and also wounds. It is this:—After evacuating an abscess or whilst dressing a wound, never inject them with an antiseptic solution unless they are in a septic condition; drain freely, if you like, but do not disturb the newly-formed tissue by forcing in a stream of water and so delay healing. Of course I do not wish to make this rule an absolute one, I do not mean to decry the external washing of wounds and irrigation, but, when everything is going on well with a wound, leave something to Nature, and remember that meddlesome surgery is bad surgery.*

As this is the last time I shall have the pleasure of meeting

*The various materials needed for the dry mode of dressing wounds may be obtained from Mr. W. A. Dyer, chemist, 16 Phillip square, Montreal.

the class during the session, I shall read to you a table which will show the operative work done during the last year, with the results obtained.

Operations performed in Dr. Shepherd's wards at the Montreal General Hospital for year ending June 1st, 1884:

Amputations:	Cured.	Died.	Total.
Thigh	2	..	2
Leg	4	..	4
Foot—Syme's	1	..	1
Chopart's	1	..	1
Lisfranc's	1	..	1
Great Toe	1	..	1
Upper Arm	2	..	2
Forearm	1	..	1
Hand	2	..	2
Fingers	2	..	2
Total	17	..	17

Of the above operations, 7 were performed for disease and 10 for injury. The following list will show the cases more in detail:—

Primary Amputations for Injury:	Cured	Died.	Total.
Leg	1	..	1
Great Toe	1	..	1
Arm	2	..	2
Hand	2	..	2
Fingers	2	..	2
Secondary for Injury:			
Leg	2	..	2
For Disease:			
Thigh	2	..	2
Leg	1	..	1
Syme's	1	..	1
Chopart's	1	..	1
Lisfranc's	1	..	1
Forearm	1	..	1
Total	17	..	17
Excisions of Joints:			
Ankle	1	..	1
Excision of Diseased Bones:			
Partial of Fibula	1	..	1
" " Tibia	1	..	1
" " Femur	1	..	1
" " Radius	2	..	2
" " Clavicle	1	..	1
Ligature of Arteries:			
External Carotid	1	..	1
Anterior Tibial	1	..	1
Ulnar	1	..	1

Removal of Tumours—*Cancer:*	Cured.	Died.	Total.
Lip	2	..	2
Side of face and neck	2	..	2
Tongue	1	1	2
Floor of mouth and submaxillary gland	1	..	1
Soft palate and tonsil	2	..	2
Sarcoma:			
Neck	2	..	2
Non-malignant Tumours:			
Glandular of neck	4	..	4
" " groin	2	..	2
Neuroma of arm	1	..	1
Large polypoid of nose	1	..	1
Bursal of patella	1	..	1
Reparative Operations:			
Imperforate Anus	1	..	1
Tenotomy	2	..	2
Drilling femur for ununited fracture	2	..	2
Incision and drainage of large abscesses:			
Gluteal region and thigh	2	..	2
Ischiorectal	4	..	4
Perineal	2	..	2
Parotid	3	..	3
Bursal	3	..	3
Connected with diseased spine and ilium	3	..	3
Various Operations:			
Ovariotomy	..	1	1
Colotomy	1	..	1
Incision and drainage of chest	1	..	1
Incision and drainage of knee-joint	2	..	2
Radical cure of hydrocele	1	..	1
Drainage of cystic bronchocele	1	..	1
Fissure of rectum	3	..	3
Fistula in ano	4	..	4
Removal of toe nail	2	..	2
Circumcision	1	..	1
	86	2	86

There were two deaths—one after excision of tongue, from gangrene of the lung following erysipelas, and one from shock after ovariotomy. In the two cases of excision of the tongue, the lingual arteries were ligatured previous to the excision of that organ. In one case of excision of large tumor of neck, the internal jugular vein was ligatured.

SCIATICA, WITH COMPLETE LOSS OF SENSATION, ACCOMPANIED WITH TROPHIC CHANGES, ULCERATION OF THE FOOT, &c.

By J. CAMPBELL, M.D.C.M., and L.R.C.P., Edin., of Seaforth, Ont.

(Read before the Huron Medical Association.)

History.—D. C., æt. 35, a native of Scotland, unmarried, a farmer, of healthy appearance, came to me on the 22nd of June, 1883, complaining of pain behind the right knee. He said it extended to the right hip and the small of the back. He said he had been sitting up for nine nights with a sick mare in the stable, and had lain down occasionally with wet feet, with nothing but a quilt over him. He often felt very cold. He drank pretty freely at times, and being a bachelor often did not get his meals in time. As he had to cook for himself the cookery also was somewhat indifferent.

Diagnosis.—We diagnosed sciatica, which we told him was evidently produced by cold, exposure and ill-treatment generally. We prescribed blistering and tonic treatment, good nourishing diet and rest by way of cure, and to prevent a return of the malady after the cure was effected—a wife. He reported improvement from the above treatment after lying in bed three weeks. The pain gradually left, but he was astonished to find that he had lost all feeling in the outer part of the thigh and leg down to the little toe. Strange to say, that in spite of all treatment, this state of things continued for eight months. We prescribed the galvanic battery, strychnine, and tonics generally. On the 10th of February last he came to me with a swollen foot with a wound on the outer side of the little toe, which he attributed to the fact that he did not know when he hurt it, not having any feeling in the part. I found that he had been treating himself very badly, frequently getting on the spree, and discontinuing the treatment both as regards the nervine tonics and the battery for weeks at a time, and not having taken my advice in the wife business, his meals also were intermittent and of an inferior character. He was, in short, a bad subject, and did not report himself sometimes for months at a time. We applied carbolic oil to the wound, told him to raise

the foot, and rest until it was healed, and afterwards to wear a loosely-fitting slipper instead of the hard cowhide shoes he was wearing. Under this treatment the swelling went away and the wound healed. He went to work and got along for a time, but again he came back with a wound on the anterior part of the foot near the union of the little toe with the foot. The foot was red and swollen, and the part had been painful before it began to suppurate. He had also felt chilly and disposed to vomit for several days before he came to me. The glands of the groin were tender and enlarged. When foot swelled, pain ceased. It had an angry erysipelatous appearance. Temperature nearly 102°, pulse 120. As it was in the winter, and I knew that the patient had frequently drank freely and also exposed himself to the cold, I did not know whether to attribute the wound and swollen foot to frostbite or to trophic changes in the part, from the low state of vitality, or from all combined. His foot had always felt cold to the touch, but he did not feel it cold when exposed to frost, because there was no sensation in the part. We put him on the same treatment as before with the addition of large doses of quinine, which was repeated until all chilliness passed away and the temperature became normal and remained so. Rest, elevation, and tonics, with carbolic oil to the wound and lotion of plumb. acet. to the swollen foot completed the cure, if we may call it a cure, where there is only partial recovery from the symptoms complained of. The patient, however, resumed work, and has been so employed ever since.

Present condition.—The sensation has partially returned, and there are no sores on the foot or leg. It is somewhat cold to the touch and slightly swollen. He has discontinued all treatment, and is working every day. He still drinks occasionally, and no doubt will continue to do so until the Scott Act passes.

Remarks.—It was a question in my mind as to the cause of the loss of sensation, whether it was centric or eccentric. I have arrived at the conclusion, taking the history, habits, course of the disease, and present condition of patient into consideration, that the paralysis of sensation was caused by inflammation

of the sheath of the nerve, which had been followed by effusion within or around the same, producing pressure on the nerve and loss of sensation as we have described. This would also account for the trophic changes in the foot as well as other symptoms which were so unique and troublesome in this case.

Correspondence.

LETTERS FROM BERLIN.

(From Special Correspondents.)

The central figure of the Berlin Faculty is Virchow. With the exception of the years 1849-56, he has been here as student, prosector and professor since 1839. In 1844 he became assistant to Froriep, whom he succeeded as Prosector of Pathology in 1846, losing the position in 1849 on account of his active participation in the political disturbances of that period. He was, however (not without considerable trouble), reinstated, and shortly after, in the autumn of the same year, was called to Wurzburg as Professor of Pathology, and returned to Berlin in 1856. Under his direction, the Pathological Institute of the Charité has become the most famous school of pathology in Europe; and to name the men who have been his assistants, is to go over many of the best known teachers and investigators in Germany—Klebs, Recklinghausen, Rindfleisch, Cohnheim, Liebrich, Hoppe-Seyler, to say nothing of the younger men, Orth, Ponfick, Salkonski, and others. After 40 years of teaching, it is but natural that he should have much of the drudgery done by his able assistants, Drs. Jürgens, Grawitz and Israel, who conduct the autopsies and the courses on pathological histology. Students have, however, still the great privilege of hearing him in three different classes. For the first three or four Mondays of the semester, from 7.30 to 10 a.m., he performs an autopsy before the class, giving detailed directions as to methods and the proper modes of observation. On Wednesday and Saturday are held the famous demonstration courses on morbid anatomy, in which the material of the week—often 10 or 15 cases on each occasion—is brought before the students;

the time occupied is at least 2½ hours, the first half of which is taken up with some special subject, the pathology of which is well illustrated by the specimens at hand. The other morning I could not but feel what a privilege it was again to listen to the principles of thrombosis and embolism expounded by the great master, to whose researches we owe so much of our knowledge on these subjects. At 11 a.m. each day he gives a lecture on special pathology. Politics and anthropology absorb the greater part of his time. He is a member both of the German Parliament and of the Prussian House of Representatives; and I noticed a day or so ago, in one of the daily papers, an item stating the number of times which each member spoke—I forget in which House,—that Virchow had spoken on 38 occasions during the session. It need scarcely be stated that he is an advanced liberal. He is also a member of the City Council—not an idle one either, as the copious literature of the canalization (drainage) system of the city can testify, and I notice that he has been again urging the further extension of the sewers. His archæological and anthropological studies are at present most extensive, and it is upon these subjects now that he chiefly writes. When one turns to the index of authors in the volumes of "Transactions of the Berlin Archæological Society," the figures after his name stand thick and deep, just as they do in a similar index in medical works. He has been collaborateur with Dr. Schliemann in several of the important works issued on Trojan antiquities. His collection of skulls and skeletons of different races, one of the most important in Europe, will doubtless find an appropriate place in the new Archæological Museum erected by the Government. At present, his private rooms are a sort of Gehenna, which has laid every quarter of the globe under contribution. The very day on which I gave him four choice skulls of North American Indians, from Prof. Bell's collection, two large cases of skeletons of the natives of Madeira were brought in. There are those who grudge him the time which he thus spends on politics and his favorite studies, but surely he has earned a repose from active pathological work, and may well leave section cutting and bacteria staining to the smaller fry;

and when we consider that, in addition to the classes above mentioned, he is President of the Berlin Medical Society, and edits his *Archiv*, now a large monthly journal, it can scarcely be said that he neglects professional duties. On all questions of general, medical, and scientific interest, his utterances are not infrequent, and display a judicious conservatism—as witness his sound position regarding the Darwinian theory as opposed to the vagaries of Hæckel. It is satisfactory to note that the attack of gouty nephritis of some 18 months ago appears to have left no traces. Aged, of course, he is (now 63), but there is still a vigor and sprightliness in the wiry frame which bespeak years of continued activity.

"Wirklicher Geheimer Ober-medicinalrath" von Frerichs has renewed his youth with the recent jubilee, and has astonished his medical friends with the production of a monograph on Diabetes. From the way in which I heard it spoken of, it must have been of the nature of the surprise which the friends of the wife of the venerable patriarch had,—certainly it had long ceased to be with Frerichs after the manner of German professors, for he has published nothing since—it is hard to say when. Silence, however, has not meant idleness, as this work will bear comparison with his others; and what is extremely gratifying, is to notice in the preface the statement that he intends to devote the autumn of his life to the preparation of other monographs, for which the materials are at hand in his vast clinical experience. It will be of interest to give a few details from the work, which is based upon 400 cases, 282 males and 118 females. With reference to race, it is remarkable that 102 of the patients were Jews, which he attributes to hereditary excitability of the nervous system, the keen pursuit of business, and, above all, intermarriage. Only 60 of the patients belonged to the working classes. Hereditary influence could be traced in 39 cases, and one-seventh of the patients showed a tendency to obesity. The preliminary chapters are taken up with physiological details regarding sugar and glycogen. The remarks on glycosuria, or the temporary presence of sugar in the urine, are of interest; and he groups the cases under three divisions; 1, In conse-

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failing pulse, somnolence, and loss of consciousness, death
in a few hours. The second group contains cases which
considerably from the above, there being usually an initial
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or some local disease, a pharyngitis, ulcus linguæ or bronch
and one or several of these ushers in the severe symptom
headache, restlessness, delirium, occasionally maniacal outbur
dyspnœa, with or without cyanosis, and then somnolence a
coma. The breath has usually a fruity odour, or reeks strong
of aceton or chloroform, occasionally so strong as to pervade th
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diabetic. The cause of these phenomena is not yet clear, and the various views are very fully discussed. The fat emboli theory receives no support from Professor Frerichs' experience. Acetonæmia, so much discussed of late, is also disposed of, and he thinks the word should be abolished. That aceton occurs in the urine of diabetic patients is well attested; where it arises, and with what preliminary steps, are unknown. It may be given to men and animals in large doses without any serious disturbance. The recent view of Stadelmann that it is a form of acid intoxication due to the accumulation of, possibly, B-croton acid appears negatived by the absence of any reduction in the alkalinity of the blood, and by the fact that B-croton acid appears not to be poisonous. As to the cause, he thinks that in the first group the death is due to heart paralysis, but in the second and third we have to deal with a form of intoxication, as shown by the symptoms—headaches, feeling of drunkenness, the delirium, somnolence and coma, always accompanied by the characteristic changes in the urine and breath. "We have here to do with a series of decomposition processes in the blood, sometimes rapidly, sometimes slowly induced, of which we know the final products (acetessig acid and aceton), while the preliminary stages of the zymotic process in the blood are unknown, and are hard to follow on account of the easy and rapid changes of bodies of this class. We designate these zymotic (formentative) processes as diabetic intoxication."

An analysis of 55 autopsies is given. The most important and constant change in the medulla was marked dilatation of the small vessels, often accompanied by fresh hemorrhages.

As regards treatment, Prof. Frerichs thinks we have just as many resources against diabetes as against gout, emphysema, or chr. morbus Brightii, and he has had patients who have survived 10, 12, 16 and, in one instance, 20 years. Mental quietude is all important. Bodily exercise, as recommended by Trousseau, is of great service. As regards diet, a reduction of the carbo-hydrates is advised, but he thinks it better to allow the patients a little bread, and to give, as addition to the flesh, a [illegible]reen vegetables as free as possible from starch.

quence of poisons of various kinds, particularly those which cause an accumulation of blood in the abdominal viscera. Contrary to the generally received opinion, he states that ether and chloroform do not, and mentions the case of a young man who was in the habit of taking ether in the street, and hence was nick-named "Ether-Fritz," in whom, after the inhalation of 207 grammes, no trace of sugar was found in the urine. 2, Glycosuria from disturbed digestion, particularly liable to occur in gouty persons. When in perfect health, an enormous quantity of sugar may be taken daily without a trace appearing in the urine. 3, Glycosuria from nerve disturbance, psychical or otherwise. The experience is very common to find sugar in the urine of patients with extreme mental worry from business troubles. A number of interesting observations are given of glycosuria after local neuralgias and various coarse lesions of the brain and membranes. One naturally turns to see what he has to say upon the much-debated question of sudden death in diabetes. Such cases are divided into three groups, the first of which includes patients who are suddenly, or, at the most, after transient disturbance, attacked with general weakness, cold extremities, and, with a failing pulse, somnolence, and loss of consciousness, death occurs in a few hours. The second group contains cases which differ considerably from the above, there being usually an initial stage of general weakness, gastric disturbance, vomiting, constipation or some local disease, a pharyngitis, ulcus linguæ or bronchitis, and one or several of these ushers in the severe symptoms—headache, restlessness, delirium, occasionally maniacal outbursts, dyspnœa, with or without cyanosis, and then somnolence and coma. The breath has usually a fruity odour, or reeks strongly of aceton or chloroform, occasionally so strong as to pervade the room. Such cases usually last from three to five days. In the third group are the cases in which, without a trace of dyspnœa or feeling of disturbance, with moderate tension of the radials, the patient is attacked with headache, a feeling of intoxication, sleepiness, and then the fatal coma. The breath also has a characteristic odor. This mode of death is more common than is supposed, and, next to phthisis, is the chief danger to the

diabetic. The cause of these phenomena is not yet clear, and the various views are very fully discussed. The fat emboli theory receives no support from Professor Frerichs' experience. Acetonæmia, so much discussed of late, is also disposed of, and he thinks the word should be abolished. That aceton occurs in the urine of diabetic patients is well attested; where it arises, and with what preliminary steps, are unknown. It may be given to men and animals in large doses without any serious disturbance. The recent view of Stadelmann that it is a form of acid intoxication due to the accumulation of, possibly, B-croton acid appears negatived by the absence of any reduction in the alkalinity of the blood, and by the fact that B-croton acid appears not to be poisonous. As to the cause, he thinks that in the first group the death is due to heart paralysis, but in the second and third we have to deal with a form of intoxication, as shown by the symptoms—headaches, feeling of drunkenness, the delirium, somnolence and coma, always accompanied by the characteristic changes in the urine and breath. "We have here to do with a series of decomposition processes in the blood, sometimes rapidly, sometimes slowly induced, of which we know the final products (acetessig acid and aceton), while the preliminary stages of the zymotic process in the blood are unknown, and are hard to follow on account of the easy and rapid changes of bodies of this class. We designate these zymotic (formentative) processes as diabetic intoxication."

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The milk cure has done more harm than good. In gouty cases, the alkaline springs—Carlsbad, Neuenahr, and Vichy—are of great, occasionally permanent, benefit. The anti-zymotic remedies—carbolic acid, salicylic acid and iodoform—so much lauded by some physicians, are not often of permanent value.

Five beautifully-executed plates accompany the volume, illustrating the pathological changes.

Prof. Frerichs' clinic is still much frequented, and one can daily see several cases of great interest, and hear words of clinical wisdom from an experience of forty years.

The other great medical clinics at the Charité are Leyden's, general medicine; Westphal, psychiatric and nervous diseases; and Henoch, children's diseases. Prof. Leyden takes much more pains to instruct the students, who are called in groups of four or five to each case in the arena, but this often makes it rather tedious to the onlooker—as it seemed often most trying to the Professor. Certainly physical diagnosis does not seem to be a strong point in the class this semester, but most of them are beginners, and have come to learn. No clinic has pleased me more than Prof. Westphal's. I think most of us—all the members of our local medical society at any rate—take an interest in mental disease, and when presented for study in a systematic and scientific manner, it is particularly attractive. Here, as in most of the German Universities, diseases of the mind and diseases of the nervous system go together, as they should do, and Westphal's division of the Charité comprises both. After about an hour's lecture on some special subject, cases are brought in from the asylum wards in illustration, and the chief points in each dwelt upon, so far as they bear upon the subject discussed. I am glad to see that the attendance upon this clinic has greatly increased, and there are more strangers at it than at any other which I attend. The lectures on diseases of the spinal cord on Saturdays are also most intructive.

Through the kindness of Director Rolloff, I have been able to see something of the working of the Royal Veterinary College, which is in the immediate vicinity of the Charité, and under Government control. The professors live in a part of the insti-

tution, and do not engage in private practice, but each one devotes himself specially to the department which he teaches. As a consequence, there is much better teaching, and altogether a more scientific tone, than is the case in English or American institutions of the kind. The students, however, do not seem to be up to the average of our own, a fact explained possibly by the comparatively low state of the profession in the country districts and the wretched remuneration. Really first-class veterinary practices are infrequent; even here, in this large city, the Veterinary College must be a great opponent, as persons of all grades and their animals come to it to be doctored at Government expense. The new Pathological Institute, in connection with the School, is a beautiful building, admirably adapted for purposes of teaching and investigation.

I have been much interested in the abattoir, and, through the kindness of the Veterinary Superintendent, Dr. Hertwig, I have been able to see the admirable system of inspection of flesh, as well as secure a number of valuable specimens illustrating the commoner morbid and parasitic appearances. Trichinæ do not appear in some with anything like the frequency in America, but the habits of the people necessitate an army of inspectors throughout the country. There are 84 or 85 at the abattoir here, and of every hog, 24 small bits of the muscles are examined microscopically. Measles (cysticerci) in the hog is very common; every day carcasses are confiscated. Tubercle is also met with very frequently in the swine, much more so than with us. Measles in the calf and ox is rare. It is to be hoped that in Montreal the Council will see the necessity of appointing skilled inspectors, and that power will be granted to confiscate condemned carcasses and order destruction of the same under police supervision.

Prof. Liebrich's Pharmacological Laboratory, which is a building at one end of the Physiological Institute, illustrates the thorough way in which the Government deals with these scientific branches. From basement to roof the building is equipped with everything that an investigator of the action and character of drugs could desire. No expense has been spared; indeed in

some directions it has been lavish. Lecture-room, students' laboratory, museum, operating-room, with a fine suite of private apartments, makes up, perhaps, the most complete laboratory of the kind in Europe.

The modern "*hep, hep, hep*" shrieked in Berlin for some years past has by no means died out, and, to judge from the tone of several of the papers devoted to the Jewish question, there are not wanting some who would gladly revert to the plan adopted on the Nile some thousands of years ago for solving the Malthusian problem of Semitic increase. Doubtless there were then, as now, noisy agitators—prototypes of the Parsons Stocker—who clamored for the hard laws which ultimately prevailed, and for the taskmasters whose example so many Gentile generations have willingly followed of demanding, where they safely could, bricks without straw of their Israelitish brethren. Should another Moses arise and preach a Semitic exodus from Germany, and should prevail, they would leave the land impoverished far more than was ancient Egypt by the loss of the "jewels of gold and jewels of silver" of which the people were "spoiled." To say nothing of the material wealth—enough to buy Palestine over and over again from the Turk—there is not a profession which would not suffer the serious loss of many of its most brilliant ornaments, and in none more so than in our own. I hope to be able to get the data with reference to the exact number of professors and docents of Hebrew extraction in the German Medical Faculties. The number is very great, and of those I know, their positions have been won by hard and honorable work; but I fear that, as I hear has already been the case, the present agitation will help to make the attainment of University professorships additionally difficult. One cannot but notice here, in any assembly of doctors, the strong Semitic element; at the local societies, and at the German Congress of Physicians, it was particularly noticeable, and the same holds good in any collection of students. All honor to them!

W. O.

SURGICAL NOTES—BERGMANN'S KLINIK.

The operating theatre is large and well-ventilated. The floor (of porcelain tiles), the tables and the adjacent woodwork are scrubbed, and the rest of the room, seats, &c., swept, dusted, and sprinkled with carbolic acid every morning. Once a week every part of the woodwork and walls, as well as the floor of the part occupied by the students, is thoroughly scrubbed and disinfected. Moreover, the spray (carbolic 2 per cent.) plays in it for at least two hours every morning; and during this time such patients as can be brought in have their dressings changed here. The operating tables (for there are often three and even four in requisition) are covered with sheets of rubber one-third of an inch thick, which project beyond the edge so that the patient never comes into contact with the wood, and after each operation, this rubber cover is thoroughly washed with "sublimat" (Sol. Hydrarg. Perchlor. 1–1000). The patient is always completely stripped and covered with clean sheets, and a blanket if needed; these, whether soiled or not, are at once sent to the wash-house, so that they cannot possibly convey contagion to another case.

The disinfectant solutions used, as a rule, are 2 per cent. sol. carbolic acid and 1 per thousand sol. corrosive sublimate: these are always spoken of as "carbol" and "sublimat." In addition, 5 per cent. sol. carbolic acid is sometimes used for washing intestines during abdominal section, &c.; 1 per cent. sol. salicylic acid (I have only seen this used to wash out the bladder for cystitis or during lithotomy); 10 per cent. sol. iodoform in sulphuric ether, used to wash out the wound in resections, and also for tampons. The carbol and sublimat are used, as far as I can see, quite indifferently; but Fehleisen, the first assistant, who operates when the chief is absent, always uses the latter. Iodoform is used in powder where the wound is situated in a cavity, as in nose, mouth, vagina; and a 5 per cent ointment of the same drug is kept at hand to anoint the fingers before digital examinations. Iodoform suppositories are also in use. I have tried in vain to find out any principle by which the use of the spray is guided. As a rule, it is at hand, but often can be heard playing in the next room. Perhaps it is more regularly employed

during intra-peritoneal operations than in any others: yet twice lately it has been neglected, during an exploratory abdominal section and a herniotomy with excision of the sac. If used, it is made to play directly over the wound, saturating the heads of the operator and his assistants.

As to dressing materials, sublimate gauze and wadding or wool constitute 99 per cent. of what is used,—iodoform gauze, wool, or jute the rest. The sublimated gauze is made here; it is pure white, beautifully soft and light, and perfectly dry: the wool the same. Tampons made of iodoform gauze rolled up tightly and tied in appropriate sizes are always used to pack cavities or wounds which are not expected to unite at once; before use they are dipped in iodoform solution (10 per cent. in ether). Protective is not applied to the wound; but in most cases the outermost dressing consists of several layers of sublimated gauze, with a sheet of very thin rubber tissue between the two outermost layers. The bandages commonly used are of sublimated gauze, charged with a little starch; they are dipped in water just before use, and hold the dressings splendidly. Plaster bandages are also used very freely; and the limbs are nearly always steadied by the use of strips of felt, gutta percha, or light splints of wood or perforated zinc.

During an operation, all engaged are clad in clean white duck overcoats reaching nearly to the ankles; the sleeves are short, so that the forearm is always bare. If at all soiled, these are changed before the next operation. Every one washes his or her hands with soap and a nail-brush, and then dips them in carbol or sublimat, before and after each operation, and also rinses them with the solution frequently during its performance. The patient's body, in the neighborhood of the site of the operation, is also washed in the same way before and after each operation or dressing. The instruments lie in carbol; and during operation, if one is laid down for a moment, an assistant at once seizes it and washes it in pure water before restoring it to the tray, which is thus kept always clean. No sponges are used except to guard viscera against injury, &c.; but small pieces of dry gauze do instead, and are used very freely, the floor after a bloody operation being covered with them.

Irrigation is used to an extent that surprises one who has been trained in an economical school. In the room over the theatre are two large tanks, full of the solutions; long rubber tubes, furnished with ingenious nozzles, afford a means of applying these to any part in any amount. In addition, large cans, like enormous teapots, are at hand to flood the wound (and the table) whenever it seems desirable, which is very often.

Carbolized catgut is generally used for ligatures and sutures, but in many cases Chinese silk is used for the latter, and sometimes, as when great force is to be used, for the former. The only thing that one notices about the drainage tubes is their large size, fully twice as large as we are accustomed to in Montreal, and I am inclined to doubt the advantage of these unusual dimensions.

These are the principal points that struck me in regard to materials, &c. A word or two about instruments. Bergmann uses several which are seldom thought of at home. Three kinds of retractors are in use—sharp treble hooks, short broad-beaked blunt and broad long-hook-beaked blunt retractors. These are *always* used, the first and second assistants applying them as soon as the skin is incised, and keeping the wound well opened. In many cases the sharp hooks alone suffice, but in some, as in resection of the hip, ligature of subclavian, &c., when a very deep wound is made, the last-named are very useful. Single hooks of various sizes, both blunt and sharp, are also much used in appropriate cases. To me it seems these retractors are very useful, keeping the wound well open down to the bottom, and allowing an uninterrupted view of the knife; they also keep important or delicate structures well out of harm's way. The artery forceps used are those of Langenbeck—much like those known to us as "torsion forceps;" they are used in great numbers, as no vessels are tied till the end of the operation, except in cases of abdominal section, when great pains are taken to arrest *all* bleeding before opening the peritoneum. In resections and operations on bones, very strong knives of many different shapes are used, and recourse is very frequently had to chisel, gouge, or sharp spoon. All these instruments, as well as the

retractors, common scalpels and bistouries, and, in short, all instruments, as far as possible, are made of one piece of steel, the handles being plated with nickel; they can thus be made aseptic with the greatest ease. He also uses the chain-saw very commonly, and, as I have indicated, the sharp spoon—indeed the latter is almost constantly in his hands. In his operations on bone he always takes the greatest pains, by chiselling, gouging, and scraping with the spoon to remove every fragment that seems at all suspicious; and also, with scissors and forceps, cuts away all the thickened and infiltrated tissue always found about diseased bones and joints. The enormous wounds are tightly stuffed with iodoform tampons, and heal in a really surprising manner. During the use of saw, chisel, or spoon, a stream of sublimat is kept playing into the wound, which is thus kept clean. The needles used are always curved, usually fully so (Hagedorn's pattern), and rather smaller than those one sees, as a rule, in England; but as a needle-holder is another essential, they seem to be very convenient, and certainly can be used very rapidly. The continuous is the only variation I have seen on the ordinary interrupted suture. In removing sutures, a pair of small, sharp-pointed scissors, like eye scissors, are used. Instead of the usual dissecting forceps, hook forceps, large ophthalmic "fixation forceps," but much larger, are used. For cutting the stiff gauze bandages, a pair of large, strong elbow scissors, with a flat button on the point of the lower blade, seem very useful: they are called by the maker's name, Windler's. To remove plaster bandages, the ordinary plaster shears are used, and also a small saw, like the curved blade of a Hey's saw.

In the wards, all the utensils, and notably the flat pans, used to receive pus, dressings, &c., are of polished brass, and so are the irrigation cans, which hold about a quart. Over each bed is a hook for the irrigation can to be hung on. A small, narrow bench or stool, about 6 inches high, 12 inches long and 3 inches broad, covered with rubber, is much used to put under the hips, back, &c., during dressings, which are always done on a special table, unless the patient's state absolutely forbids it. The same precautions are taken in dressing as in operating. As to splints,

I have noticed nothing remarkable except the number and variety of resection splints, but plaster replaces them in the treatment of simple fractures.

In conclusion, let me say that the expense of carrying out this system must be enormous, as may be gathered from what I have written; but in this happy land the hospitals, &c., are all Government institutions, and have practically *carte-blanche*. And the director (in this case Ernst von Bergmann) is an absolute sovereign in his own institution. *Oh si sic omnes.*

R. J. B. H.

Reviews and Notices of Books.

The Dissector's Manual.—By W. BRUCE-CLARKE and C. B. LOCKWOOD. London: Cassell & Co. Philadelphia: Henry C. Lea.

This little book is one of the now very popular series of text-books in course of publication by the above-mentioned firms. It is less fortunate than its predecessors, inasmuch as they supplied a decided want. There was no work on surgical pathology exactly suited to the requirements of the English examining bodies, so that Mr. Pepper's book came at once into demand. The Applied Anatomy of Treves and the Histology of Klein, for the same reason, found many readers; but it will take a dissector's guide of very extraordinary merit to supersede the old favourites—Ellis, Heath, and Holden.

The authors have recommended a plan of study somewhat unusual. The student is to master the book description of the individual parts at home with his Gray or his Quain, the guide is to show him the proper mode of applying the knowledge thus gained. Hence parts, muscles, arteries, &c., are not separately described, but the leading points of each dissection and the relative position of structures are indicated. Where space is so limited the introductory chapter might well be omitted, including the glossary of anatomical terms, which is quite unnecessary. Certainly words in such common use as "demonstrate," "capsule," "dissect," "ligament," "organ," "flex," do not need special definition. The directions for the preparation of sub-

jects for dissection, though brief, we have found more useful than those contained in volumes much more pretentious. The preservative injection of arsenic and carbolic acid experience enables us to recommend. It preserves the subject without rendering the tissues hard, and does not act upon the vessels in such a manner as to prevent their receiving a full charge of the colouring material. As a rule, the descriptions of the parts which present most difficulty to the student are well done, and by means of the well chosen familiar examples used ought to be well understood. Particularly we refer to the perinæum, the parts concerned in hernia, and the pelvic fascia. The chapter on the brain is to be commended. The subject is treated briefly, but no point of real importance is omitted. An excellent diagram illustrates that part of the description in which so many writers break down, the continuation of the fibres of the medulla into the cerebrum and cerebellum.

The fact that no urgent need of such a book exists does not prevent us from according to the authors the praise they deserve for the manner in which they have compressed such a large amount of valuable anatomical information into so small a space, while at the same time their style of writing has been found most readable and attractive.

The General Practitioner's Guide to Diseases and Injuries of the Eye and Eyelids.—By LOUIS H. TOSSWILL, B.A., M.B., Cantab, M.R.C.S., Surgeon to the West of England Eye Infirmary at Exeter. London: J. & A. Churchill, 11, New Burlington Street. 1884.

This is a neat little manual treating of those diseases and injuries of the eye which are most frequently met with by the general practitioner. Such important affections as purulent ophthalmia, ulcers of the cornea, iritis, &c., which every practitioner should be prepared to treat, are described fully but concisely, so that "he who runs may read," while on the other hand, cataract, glaucoma, and the more obscure affections of the eye are merely mentioned in connection with their diagnosis, as they are usually referred to the specialist for treatment.

The chapters on foreign bodies and injuries are likewise concisely written. In fine, we know of no manual on the diseases and injuries of this important organ which is likely to give more general satisfaction to the busy practitioner.

Pathology, Diagnosis, and Treatment of Diseases of the Rectum and Anus.—By CHARLES B. KELSEY, M.D., Surgeon to St. Paul's Infirmary for Diseases of the Rectum, &c. New York: William Wood & Co., 56 & 58, Lafayette Place. 1884.

As one of the series of "Wood's Library of Standard Medical Authors," this work appeared a little over a year ago, and was then reviewed in these pages. It appears now in an entirely new dress, being much enlarged and embellished with two chromo-lithographs, besides many original illustrations. The chapter on Rectal Hernia has been also added entire.

Since the last issue the author has found reason to modify his views somewhat regarding the treatment of hemorrhoids, a subject always of considerable interest to the surgeon. He was then decidedly inclined to favor the treatment by ligature. Now he strongly advocates injection with carbolic acid of the strength of about five per cent. The great objection to this plan is the length of time required to effect a cure, often three or four months, the applications being repeated twice a week. This method may prove a great financial success to the specialist and is doubtless safe, but it does not commend itself to us at present. Smith's treatment by clamp and cautery receives favorable notice.

The chapter on cancer is full and well written. With a view to arriving at a knowledge of what experience has already taught in connection with the treatment of this disease by excision, the author has collected the reports of 140 cases, from a study of which he has arrived at the following fairly just conclusions regarding this operation:—

1. Although there have been a few cases of excision in which the cancer has not returned in a number of years, such a result is so rare as not to justify the exposure of the patient to the risk

of immediate death which attends the attempt to remove extensive disease.

2. The operation is chiefly valuable as a palliative measure, and as such compares favorably with colotomy both in prolonging life and relieving pain.

3. When the disease reaches above three inches from the anus, or involves neighbouring parts so as to render its entire removal, without injury to the peritoneum, questionable, the operation is contra-indicated.

4. The operation is not followed by any annoying after-consequences which are of sufficient gravity to contra-indicate its performance.

Some space is given in the last chapter to the important subject of rectal alimentation. Altogether the work has much to commend it, and we predict for its enterprising author a brilliant career in this limited department of surgery to which he is apparently giving special attention.

Illustrations of the Influence of the Mind upon the Body in Health and Disease: Designed to Elucidate the Action of the Imagination.—By DANIEL HACK TUKE, M.D., F.R.C.P., LL.D., &c. Second American from the Second English Edition. Philadelphia: Henry C. Lea's Son & Co.; Montreal: Dawson Brothers.

The mere fact of a work with the above philosophical title reaching a second edition is sufficient evidence that the author has done his part well. It is also a proof that in spite of the utilitarianism of the age we live in there are sufficient readers to take a lively interest in such a so-called "non-practical" subject.

It is, however, not strictly correct to style the work as being ulterior to the every day uses of the physician in his battle with disease and death. We feel assured that he who rises from a careful perusal of it, especially that part dealing with the application of the influence of the mind on the body to medical practice (psycho-therapeutics) will be the better enabled to deal

with many of those obscure bodily and mental troubles which are so common. In estimating the often contradictory effects of drugs upon the human system, the influence that the mind takes in determining this action is very seldom inquired into. In some measure the utterly contradictory reports that are constantly being published and with which the medical journals of the day are full, are explained only in this way. Dr. Wilks in his lectures on the Diseases of the Nervous System, says that the physician "soon finds that in treating his patient, the practice of medicine is not only one of physic but of psychology, and that the effects of his drugs *depends as much upon the constitution of the patient's mind as his body*. I know several persons, amongst others, two notable examples in our profession who say they cannot take physic; they mean that two or three grains of rhubarb will violently purge them, that a few drops of opium upset their livers and stomach for several days, that three grains of iodide of potassium will cause coryza and headache, and so on through the whole list of drugs. These very unpleasant people and unsatisfactory patients are counterbalanced by our old and steadfast adherents, who ask for a prescription with confidence, and declare that whatever you give them does them good."

The following case shows how the strange manifestations of hypnotism may be utilized in treating insanity:—Dr. Huggard, the medical superintendent of the Sussex House Asylum, had a patient, a lady of 45, labouring under melancholia with cataleptic symptoms, who refused food with great obstinacy. "Impressed with Dr. Hack Tuke's paper on 'hypnotism,' and Tamburini and Sepilli's experiments on the same subject," Dr. Huggard had recourse to this agent. The dangling of a bunch of keys for a few minutes before the patient's eyes brought on the hypnotic sleep. While in this state any idea suggested was believed, and commands were obeyed. She was ordered to eat and she ate. She was ordered to drink and she drank. She was ordered to go through various quick movements, and she did so. She was told she was the happiest mortal in the world, and was desired to laugh; her face lighted up, an unaccustomed

smile came upon her lips, the croaking noise of unwonted and almost forgotten laughter was heard, which soon, however, with practice, softened into more natural sounds. Hypnotism was employed off and on for a week, and was then discontinued, lest a habit should be formed, but during the employment of this means marked improvement was observed which had continued, and now the lady was convalescent. In this case a new device was adopted to compel the ingestion of food. But more than this, an opportunity was afforded of reaching and exciting to action long disused nervous channels. Dr. Tuke gives a great array of cases where the influence of mental anguish has caused the hair to become gray. In some instances where this change was noticed it was found that there was "an accumulation of air globules in the fibrous substance of the hair."

The influence of the mind on sensation, on the voluntary and involuntary muscles, and upon the organic functions, is dealt with very fully and very learnedly.

The Field of Disease: A Book of Preventive Medicine.—By BENJAMIN WARD RICHARDSON, F.R.C.P., Honorary Physician to the Royal Literary Fund. Philadelphia: Henry C. Lea's Son & Co.

This book, bearing a somewhat singular title, is one intended by the author to educate laymen in correct principles of medicine and their application to the prevention of disease. It was written, he states, "for those members of the intelligent reading public who, without desiring to trench on the province of the physician and surgeon, or to dabble in the science and art of medical treatment of disease, wish to know the leading facts about the diseases of the human family, their causes and prevention." The publishers, however, claim for it that, though intended primarily for the public, still "it contains much with which every physician should be familiar, while there is no work in the language in which the information here presented can be sought, systematically arranged, and intelligibly presented. From an examination of its chapters we are quite ready to agree with the latter statement, and consequently introduce

it with pleasure to our readers. The first part "Diseases" contains outlines of the various classes of diseases: this is not specially instructive to medical men, being rather elementary in in character. The second, on "acquired diseases," is divided into those from inorganic and organic poisons, those from physical agencies, mechanical and general, and the third, those from mental agencies, moral, emotional, and habitual. In many parts these chapters are highly interesting. The third section is "a practical summary of the origins, causes, and preventions of disease," and really contains the gist of what is known on the general subject of the etiology of disease and the most approved ideas concerning the combating of these by various hygienic means. It will be found a very useful book for reference upon many of those points which so frequently arise.

A Study of the Bladder during Parturition.—By J. HALLIDAY CROOM, M.D., F.R.C.P.E. Edinburgh: David Douglas. 1884.

The author is one of the physicians to the Edinburgh Royal Maternity Hospital, and the observations on which the work is based were made at that institution. They were communicated first in the form of papers to the Edinburgh Obstetrical Society and are now presented to the profession in collective form in this little monograph.

The object of the inquiry is to ascertain the extent and manner in which the bladder and its contents are influenced by parturient efforts. This was done by introducing within the bladder a No. 8 rubber catheter to which a piece of rubber tubing was attached, thus connecting the bladder of the patient with an apparatus containing a column of mercury with a graduated scale. All necessary details being arranged the effect of the pains was observed on the mercury and the pressure force of the pains on the bladder thus calculated. Our space will not permit of a detailed description of the author's methods and apparatus, but we give the most important of his conclusions:—

1st. That pressure is brought to bear on the bladder during labour.

2nd. That during the interval of pain bladder-pressure amounts practically to *nil.*

3rd. That in ordinary labour the maximum pressure is about 3.2 lbs. on the square inch.

4th. This pressure is obtained during the second stage of labour, but accidental high readings may be got during the first stage, if by accident any voluntary effort is interposed.

5th. That in ordinary labours the minimum pressure amounts to ·1 lb. on the square inch, and that this is found during the first stage of labour.

The work is illustrated by a number of wood-cut diagrams and a series of eight tables. The second part of the work consists of an interesting paper on the bladder during the early "puerperium," as our Scottish friends have it. This little monograph must be regarded as an important contribution to the subject. We commend it to our readers. It is dedicated to Professor A. R. Simpson.

A Manual of Obstetrics.—By A. F. A. KING, M.D., Professor of Obstetrics and Diseases of Women and Children in the Medical Department of the Columbian University, Washington, D.C., &c. With 59 illustrations. Second edition. Philadelphia: Henry C. Lea's Son & Co.

We have already had occasion to direct attention to this book in its first edition which appeared but a short time ago. A few additions of a useful character have been made. It is one of the best of the modern handy manuals on this branch of medicine. It has been well received and become popular both in the United States and in this country, and we believe its popularity to be well deserved. It will be found especially suitable for students, and for the guidance of young practitioners.

Books and Pamphlets Received.

SEXUAL NEURASTHENIA: WITH A CHAPTER ON DIET FOR THE NERVOUS. By Geo. M. Beard, A.M., M.D. Edited by A. D. Rockwell, A.M., MD. New York: G. B. Treat.

AUSCULTATION, PERCUSSION AND URINALYSIS. Edited by C. Henri Leonard, A.M., M.D. Illustrated. Issued by the Illustrated Medical Journal Co., Detroit, Mich.

A NEW METHOD OF TREATING CHRONIC GLAUCOMA, BASED ON RECENT RESEARCHES INTO ITS PATHOLOGY. By Geo. Lindsay Johnson, M.B. Illustrated. London: H. K. Lewis.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, April 25th, 1884.

DR. HENRY HOWARD IN THE CHAIR.

PATHOLOGICAL SPECIMENS.

DR. R. L. MACDONNELL exhibited a *radius* found in the McGill dissecting-room, shewing an old Colles' fracture; also a *skull*, the parietal bones of which were very thin over the grooves for the middle meningeal artery. This was pointed out to be of medico-legal interest, inasmuch as a moderate blow on the side of the head might produce death by fracture of the bone and perforation of the vessel.

DR. HENRY HOWARD said that the late Dr. Macdonnell saved a cab-driver from the gallows by showing in court that the skull of the person whom he had struck on the head for refusing to pay him was abnormally thin in this region, death being caused as above.

Syphilitic Teeth.—Dr. MacDonnell showed a plaster cast of teeth from a boy who has been under his care for about two years suffering from well marked symptoms of congenital syphilis.

DR. SUTHERLAND exhibited the following:—

1. *Monstrosity.*—Drawing of a two-headed fœtus and skeleton of the same from Dr. Mullins of Hamilton. The child (male) had two heads, four arms, and two legs. The skeleton shewed two separate vertebral columns converging at the sacrum, and two thoracic cavities, one abdominal.

2. *Hemorrhage into the Cerebellum.*—The right lobe of the cerebellum was torn up by the force of the blood. This specimen was removed from a boy aged 13 years, who, while apparently in good health, was suddenly seized with a convulsive fit, dying almost immediately.

3. *Brain of a Monkey*—Showing the cerebellum fully covered by the cerebrum.

Dr. Sutherland also showed the *Skull and Brain of an Idiot*, the main features of which were as follows:—Of the skull: The

capacity of the cranium comes under the group of microcephalic skulls. The bones of the face are large in comparison with those of the cranium, and slant forward. The horizontal circumference taken in a plane passing anteriorly through the ophryon and posteriorly through the occipital point, 17½ inches; arch of the vault from the ophryon to the occipital point, 10 inches; transverse circumference from one auricular point to the other, 10 inches; width between the malar bones, 3 inches. Orbits are comparatively large, 2 × 1½ inches. Superciliary ridges prominent. Nasal septum between them is narrow. The ophryo-alveolo-auricular angle gives a prognathic index. Temporal fossæ are deep, and ridges well marked. Basi-occipital process ascends very obliquely to articulate with the basi-sphenoid. Foramina at the base are comparatively large; the grooves for sinuses comparatively small. The brain has a low, contracted appearance, short, greatest transverse diameter being at the middle of the mass, and having a ratio to the length of 1 to 1½. Far from being concealed, the cerebellum projects behind the cerebrum to the extent of one inch, and forms a fourth part of the whole mass. In the base view the relative preponderance of the cerebellum is again the most striking feature—

Antero-posterior diameter of the cerebrum			5 inches
Hemispheric arch			6 "
Anterior curve (fiss. of front. lobe to fiss. Rol.)			3 "
Middle "	(fiss. Rol. to par. occip. fiss.)	right side,	1 "
		left "	1½ "
Posterior "	(par. occip. to fiss. of occip. lobe)	right "	1½ "
		left "	1 "

The frontal region is short and pointed; the orbital surface but slightly marked. Temporal convolutions are large, and are continued backwards into the occipital lobes, which are exceedingly small and cannot be definitely divided into their ordinary number of convolutions. The central lobe is exceedingly small. The parts which can be detected as actual convolutions are: Frontal parietal lobules—temporal, marginal, calloso-marginal, cuneate and præcuneate lobes. Less easily the orbital, occipital and central lobes—triradiate sulcus, corpora-striata and optic thalami. On the right side the fissure of Sylvius is continuous with the post-central and interparietal sulci. On both sides the calcarine

fissure is represented by two parallel sulci separated by a ridge of convolutional substance better marked on the right side. Further development of the convolutions above and below would have concealed this ridge and left a single fissure. Cerebellum more highly developed than the cerebrum.

DR. HENRY HOWARD made the following remarks on the brain demonstrated by Dr. Sutherland:—With your permission, Sir, I will read a copy of a letter I wrote to Dr. Richard MacDonnell bearing date September 16, 1883:

"I have a perfect recollection of the man that you spoke to me of. He was admitted into the asylum as a dangerous imbecile, a man with homicidal tendencies. When I first saw him I was struck with the peculiar shape of the head. It was conical. The apex of the cone appeared to be at the union of the sagittal and lambdoidal sutures. The os frontis ran back as if it formed a part of the point of the cone. The base of the cone was out of all proportion with the face, being nearly twice as large. The head and face formed two lines, and their bases united. The man's eyes were small and gray; he was what you might call pig-eyed. His walk was that of a man with locomotor ataxia. When he came towards you, you felt as if he would run over you.

"*Physiological symptoms.*—He was generally very good-natured, but terribly impulsive; the slightest thing would rouse him into a fury, when he would froth from the mouth and not be able to utter a word. At the best of times he spoke with hesitation, not impediment of speech.

"I know nothing of what disease he died of. It must have been a sudden death, as I never saw him in the Infirmary, and I see all the patients every week. I have no history of the man before he was admitted into the asylum. In your examination of the brain I would expect you to find the following conditions: Convolutions, particularly in the lateral and anterior portions of the hemispheres, flattened with irregular and shallow fissures; the cells in their cortical substance (that is, of these convolutions) few and small,—in fact, teratological defect in the whole of the motor and inhibitory nerve centres. And why would I expect you to find this abnormal state? Because the man was a very low order of imbecile, but little intelligence, and no power of controlling his impulses. I would expect to find some abnormal state of the Island of Reil, or the convolutions covering it, because of the hesitation in his speech. I would not expect to find much abnormality in the convolutions or gray substance in

the posterior lobes of the hemispheres or sensory nerve centres, because I never found any symptoms of either anæsthesia or analgesia. There was such a want of equilibrium in the man's movements, and he was such a victim of impulse, I would expect to find a very abnormal state of the mesencephalon, particularly about the basal ganglia, such as the corpus striatum and optic thalamus. I would expect the cerebellum to be large, and not covered by the posterior lobes of the hemispheres. There may be other abnormalities in the mesencephalon, but those I have mentioned I would expect to find.

"Yours always, H. HOWARD."

From the demonstration given you by Dr. Sutherland, you will perceive that, guided by experimental and clinical physiology, I made a good diagnosis of the teratological state of this man's brain, so far as the examination has gone, the doctor not having cut into the brain or made a histo-pathological examination of it. I admit that, in diagnosing flat convolutions and shallow sulci, I was as much guided in forming my opinion from the shape of the cranium as I was from the man's peculiar hesitation of speech and counduct. Judging by the frontal and lateral convolutions of the anterior hemisphere, we may easily conclude that there was teratological defect in the Island of Reil. Neuro-pathologists tell us that in the normal brain there are forty-four convolutions, and that sixteen of these are situated in the frontal lobes. In this brain there are only thirty convolutions, and eight of these in the frontal lobes. Mind, at least as we know it, being a phenomenon or force of matter, the psychosis must be what the physiology of the matter, of which it is the phenomena or force, makes it. This you have well exemplified in the imbecile's brain before you—the whole mass of the man's brain resembling more the brain of an ourang-outang than that of an ordinary man. It is a hard matter to give a definition of sanity, insanity, and imbecility that would be acceptable to all, particularly to judges that have to adjudicate in criminal cases. The reason in obvious. Some consider the mind to be soul or entity, causa vera; others, like myself, look upon mind, as far as we know it, as a phenomenon or force of matter. What is sanity? I answer, it is an equilibrium of mental forces or phenomena, due

to the physiology of physical organisms; and sanity or intelligence differs in degree, depending upon the physiological state of physical organisms. What is insanity? A physical disease, to be diagnosed by the person's psychosis and conduct, due to a loss of equilibrium of mental phenomena or forces, the result of pathological defect of physical organisms; and insanity differs in degree, depending upon the greater or lesser degree of the pathological defect of physical organisms. What is imbecility? It is a want or absence of equilibrium of mental phenomena or forces, due to teratological defect of physical organisms. Imbecility differs in degree, depending upon the greater or lesser degree of teratological defect in physical organisms. It is from the imbecile class that we get another class of society, viz., the criminal class, therefore the necessity of having the imbecile class cared for, but separated from society.

You perceive, gentlemen, that physical science naturally leads me to be a physiological psychologist, and I maintain that for physical effect there must be physical cause; therefore, that for all psychical phenomena or force there must be physiological cause. In the brain before you, taken from an imbecile, this truth is fully established. You may ask me, If mind is a phenomenon or force of matter, how is it that mind acts upon matter? I am sure that all nature's forces, which are phenomena of matter, whether organic or inorganic, not only act upon other forces, but react upon the cause. For example, you see it every day. Fire is a phenomenon of matter which acts on the very matter of which it is the force or motive. Atmospheric electricity or lightning is a phenomenon dependent upon the physiological state of the atmosphere. So does mind act upon the very organs of which it is the phenomenon, as well as it acts upon other organs. It is the antagonism of forces, when equal, that creates an equilibrium in nature, and not only in nature, but in our organisms. Therefore, as I have said, sanity is due to an equilibrium of mental forces, and insanity and imbecility to a loss of equilibrium of physical and mental forces. You will understand, then, that when I, or any other physiological psychologist, speak of the locality of the organ of intelligence being situated in the anterior

hemisphere of the brain, the motor organs in the lateral hemispheres, and the organ of consciousness in the posterior lobes, it is not meant by such statements to imply anything more than nerve centres with particular functions. It is not meant that such centres are independent of one another, or independent of other nerve forces. These terms are used for want of a better that would imply as much. The whole nervous system constitutes mind matter, as well as the brain and spinal cord. All centripetal nerve forces, or forces running towards the centre by means of the afferent or sensory nerves, find their centres in the posterior lobes of the cerebrum; therefore this centre is called the organ of consciousness. But should there arise any abnormal state of these afferent nerves by which the centripetal current would be cut off, there would be, so far, a loss of consciousness, although the nerve centre might remain normal. Again, if there was an abnormal state of any of the efferent or motor nerves by which the centrifugal current would be arrested, loss of motion in the peripheral nerve would take place, although the motor nerve centre was in a normal state. So is it with all other nerve centres—the eye, the ear, &c. All nerve centres are dependent upon each other for the perfect working of organic forces, and when all are normal, there is an equilibrium of organic forces, and there is an intellectual man. But when any of these forces are abnormal, then there is loss of equilibrium of forces, and a consequent loss of intellect to a greater or lesser degree, depending upon the abnormality of the affected organ. This is physiological psychology, or cause for effect, which is vastly different from the psychology of the past, which was based upon the supposition that mind was entity, or causa vera, and not what physical science or experimental philosophy has proved it to be, as far as we have any conception of it, a phenomenon or force of matter.

Our penal code is based upon the dogmatic *à priori* or speculative philosophy, which assumed that mind was entity. Hence the uselessness and absurdity of a physiological psychologist pleading before a judge of a criminal court. The ontological psychologist and the physiological, or experimental psychologist,

look upon crime from two different standpoints; therefore they never can come to the same conclusion as to cause and effect.

Since I wrote the foregoing I received the April number of the CANADA MEDICAL & SURGICAL JOURNAL, and in it perused with great pleasure, and, I hope, profit, a letter from Strasburg, over the signature "T. W. M.," in which the following occurs: "Professor Solly, before, perhaps, the most crowded house of the whole semester, detailed results of his latest experiments on the cerebrum. Solly opposes the theories of Hitzig and Ferrier with the deepest conviction that they are baseless. His results are very striking, and I doubt if it is possible for anyone to see Solly operate, remove a very considerable part of the fore-brain, and then note the results in the dogs, and still believe in the Hitzig-Ferrier localization theories."

You see in my remarks I have been anticipating "T. W. M." who, it appears to me, with Solly, misunderstands these physiological psychologists, Hitzig and Ferrier, and no matter what may be the result in dogs that have had a part of the fore-brain removed, it would be far from settling so important a question. "There may be localization, and this Solly admits, but not as we have heard of it as yet." Most undoubtedly there is localization, but not in the manner that Solly is looking for it; when he takes a wider view of the physical phenomena of force he will find it. Again, "T. W. M." says, "many suppose the localization hypothesis derives powerful support from clinics and pathology, from symptoms and morbid anatomy." Most undoubtedly they are many who believe it, and with good reason: see the brain before us this evening; morbid anatomy confirms the truth of the opinions formed from symptoms and clinical observations. No doubt but that there has been some wild writing upon the localization hypothesis, and that great misunderstanding has arisen from our terminology, nevertheless there must be physical cause for physical effect, and the effect must depend upon the physiology of matter, and our duty is, where we see effect, to search for, and, if possible, find out cause.

Extracts from British and Foreign Journals.

Unless otherwise stated the translations are made specially for this Journal.

Bandy-Legged Irish Children.—The writer believes that an adequate explanation for the affliction may be found in the habits of the Irish people. It is well known that all over the south and west of Ireland thousands of the peasantry live in mud cabins, which are for the most part several feet below the level of the surrounding soil, many of them destitute of windows, doors, and chimneys, the places of which are supplied by simple holes. The cabins are warmed by a peat-fire in the centre of the burrow under the hole in the roof. The fuel is got from the adjacent bog, and its smoke would speedily blear and blind the eyes of any stranger who might venture to go inside. Such holes are continually damp, and are hot-beds (or rather *cold* beds) of rheumatism, rickets, osteomalacia, and various other diseases. There are generally half a dozen or more miserable children, huddled together for mutual warmth in the cold months, along with the parents, in addition to whom there is generally at least one full-grown pig, with perhaps a litter of young ones. The food of the family consists chiefly or entirely of potatoes, and it is seldom, indeed, that any of the members see bread or meat, although occasionally a little fish, in the shape of eels from the adjacent "bogholes," may find its way to their mouths.

According to Marshall ("Human and Comparative Physiology"), "potatoes are a weak food, one pound being only equivalent to about six ounces of bread, or four ounces and a half of lentils; they are not much more nutritious than the succulent vegetables." It follows that, in order to support the body at all, enormous quantities must be eaten. The stomach expands to accommodate the huge bulk of this inefficient food, the body becomes paunchy, and the limbs of children, enfeebled by rachitis, occasioned partly by the miserable food and partly by the unwholesome surroundings, bend under the weight of the trunk, and the deformity already described is the result.—*Dr. George Hay, in Popular Science Monthly for July.*

A Case of Gluteal Aneurism.—A paper on this subject, of which the following is an abstract, was recently read before the Clinical Society of London by Mr. G. R. Turner :—

Samuel P., aged 51, coachman, was admitted into the Seamen's Hospital, Greenwich, on September 17th, 1883. He had been previously under the care of Mr. Roper, of Lewisham, from whom the following history was obtained :—On September 5th the patient was thrown out of a pony carriage, and when seen by Mr. Roper, was found to have a scalp wound, exposing bone on the right side of the head, and a contusion of the back, right hip, and buttock. He did well till September 14th, when, without leave, he got up. On getting back into bed he felt something snap in the right buttock. Immediate swelling came on, and when Mr. Roper saw him, this swelling had most distinct pulsation. Ice was applied locally, and in two days the pulsation ceased and the tumour became hard and painful. On his admission into the Seamen's Hospital, the integuments over the swelling were inflamed, and there were marks of fading bruising extending over the buttock up to the scapula. No pulsation or thrill in the tumour, which measured some eight inches by six. The man had been a hard drinker, probably had had syphilis, and both radial and temporal vessels were atheromatous. There was some slight fever on his admission. This subsided after a few days' rest, and the condition of the integuments became less inflamed. The tumour, however, became larger, and fluctuation marked. At one place the skin, on September 30th, was prominent and thinned, the superficial inflammation returned, and the temperature rose again. On October 9th, it was evident a portion of the skin had lost its vitality, and that the tumour was on the point of bursting. Exploratory puncture with a fine trochar showed that the superficial part of the swelling was solid, and gave rise to a flow of bright arterial blood from the deeper part with no relief to the tension. On October 10th the patient was put under ether, the sac of the aneurism laid open from end to end, and more than 42 ozs. of disintegrating blood clot turned out. An oval aper-

ture about the size of a split pea was found in the gluteal artery just as it left the pelvis. A carbolised silk ligature was placed on either side of this, and tied. The vessels were diseased. During the operation the rectal lever was used, and but very little blood, except that in the sac of the aneurism, was lost. Previous examination by the rectum showed the swelling was extra-pelvic. The gluteus medius, minimus, and the external rotators of the thigh were exposed at the bottom of the sac. The gluteus maximus was completely destroyed. The wound was plugged with a carbolized sponge, and dressed with carbolic gauze. The man did well for eight days, when tetanus attacked him, and he died exhausted on the eleventh day. By that time the wound was granulating healthily; all the sloughs had separated, and all ligatures had come away. No injury to the gluteal nerve could be detected. At the operation the vessel was completely isolated, and seen perfectly before ligature. No *post-mortem* examination could be obtained. The diagnosis in this case presented no difficulty, although, but for the history, the swelling at one time might have been mistaken for an abscess. It bore no resemblance to tumour of bone. At first it seemed possible that a natural cure would result, and it was not until the tumour was on the point of bursting that operation was undertaken. As the danger of secondary hæmorrhage is so very great, laying open the sac was delayed as long as possible. The rectal lever proved most efficient and should be superior to an abdominal tourniquet in such cases.—*Medical Times.*

Transmission of Tuberculosis.—The presence of bacilli of tuberculosis in the blood, in chronic tuberculosis, has a bearing upon hereditary transmission of tuberculosis, and also upon its spread by vaccination. For if a bacillus can reach the innermost tissues of the economy, why may it not travel also from the blood of the mother to that of the embryo? Why, too, may it not be transferred with the vaccine lymph. The possibility of either event dare not be denied, if Koch's views be acknowledged. At the same time, even admitting such possibility, it is plain that the chances of such an accident are so

few, that we need not be influenced in our practice as to vaccination; while natural difficulties in the way of transmission from the blood of the mother to that of the embryo account for the frequency with which the children of tubercular parents escape the malady. In like manner, it is a legitimate result of these facts, that it is not venereal disease alone which may be communicated from the male to the female in coitus. The man with tuberculosis of the seminal vesicles and urethra may inoculate the woman with whom he has intercourse, and thus produce a tuberculosis of the uterus and Fallopian tubes. Weichselbaum tells us of a case of tuberculosis of the seminal vesicles and urethra, in which the number of bacilli was enormous. A seminal fluid in such cases would naturally be loaded with bacilli, which, carried up into the cavity of the uterus, might plant themselves in such favorable nidus as happens to be present. It is fortunate, in view of these facts, that tuberculosis of the genital apparatus of the male is as rare as it is, else we would find such mode of transmission more frequent. In the meantime it behooves practical physicians to bear these views in mind and apply to them the test of experience and observation.—*Med. News.*

Use of Forceps in Breech Presentations.—Dr Truzzi is strongly in favor of the use of forceps in breech presentations. He says that, in cases of impaction of the breech in the upper or middle parts of the pelvic cavity, the prompt extraction of the fetus being indicated, and while one of the hips is not yet rotated under the arch of the pubes, it is better to have recourse to the application of the forceps to the fetal pelvis than trust to traction on the groins, which is insufficient if practiced with the fingers, and dangerous with the blunt hook or fillet. The proposal of Olivier to apply the forceps on the thighs rather than to the pelvis of the fetus, though seductive theoretically, does not work practically. It is difficult to limit the pressure of the forceps to the thighs alone; and if this be not done the abdomen would be pressed on, and possibly even the liver injured. The concave extremities of the forceps pressing on the convex surface of the thighs, slip downwards

and forwards, and after a few pulls the original good hold is lost. Much easier and safer is the plan of applying the forceps to the side of the fœtal pelvis. The iliac bones at this period are so elastic, and, compared with the bones of the head, are so protected by the soft parts, that even if the force of compression be somewhat abused, it is difficult to injure the fœtal pelvis. To obtain a firm hold, the extremities of the blades must be passed beyond the crests of the ilia, and when the handles are approximated they bury themselves slightly in the walls of the abdomen, and, on traction being applied, bear on the crests of the ilia, and at the same time impart to the hips of the fœtus a convexity to which the concavity of the blades of the forceps exactly adapts itself. The liver runs no risk since, large as it is in the fœtus, it never descends to the level of the crest of the ilium; besides, its lowest part is the thin edge of the right lobe, which may be displaced inwards, but not lacerated or contused by pressure of the forceps. The same may be said of the intestine, which from its motility avoids even the consequences of considerable pressure if this be made in a methodical and and skilful manner. A folded cloth may be placed, as suggested by Tarnier, between the handles of the forceps, to prevent too much compression. The forceps takes a better hold, and the author has never seen it slip in sacro-anterior positions. He recommends, in some cases of sacro-posterior positions, that the position should be altered by a forcible rotation of the sacrum forwards before using traction. It is better, he says, to keep up a certain amount of compression in the intervals of traction; if this be not done, the iliac wings, by their great elasticity, tend to resume their normal place, and the forceps may be displaced.—*Lon. Med. Record.*

Duration of Menstrual Hemorrhage.—In a paper on "The Duration of the Menstrual Hemorrhage in Relation to the Development of the Fœtus at Term, and to Multiple Pregnancy," the author seeks to establish his conclusions on the basis of much statistical material collected in the clinics of Modena, Milan, and Turin. He was led to this

research by the idea that by the amenorrhea of pregnancy a so much greater quantity of maternal nourishment was retained for the benefit of the fœtus, as the sanguineous loss was greater in menstruation. Not being able to determine exactly the quantity lost at each period, he took its duration as a guide, which, considering the number of his observations, may be regarded as more or less equivalent. As to a longer duration of the menstrual hemorrhage, a corresponding ovarian activity can be supposed; so also the hypothesis may be justified of a more easy rupture of more ovisacs, and a greater probability of multiple pregnancy. From the analysis of very numerous observations, Professor Cuzzi thinks himself justified in formulating the following conclusions: (1) The weight and length of the fœtus at term are in direct relation with the number of days menstruation occupied. The longer the usual period of menstruation, the heavier and larger the fœtus. (2) There is a direct relation between multiple pregnancy and the duration of the menstrual period. That is, multiple pregnancy is most frequent in women in whom the period is long and the loss free.—*Lon. Med. Record.*

Recent Views on the Origin and Nature of Pneumonia.—Perhaps the most important subject considered at the recent Congress of German physicians, sitting in Berlin, was pneumonia. The original paper was read by Jürgensen, of Tübingen, and the *confrére* to whom had been referred the consideration of the pneumonicoccus was Fraenkel, of Berlin. The discussion was participated in by Gerhardt, of Würzburg, Fraentzel, of Berlin, Ruehle, of Bonn, Nothnagel, of Vienna, Rosenstein, of Leyden, Baeumler, of Freiburg, and Edlefsen, of Kiel. At the same time, the results can scarcely be considered commensurate with the importance of the subject. Within a few years past the views so long current as regards croupous pneumonia, that its cause is cold, its nature inflammatory, its initial symptom a chill, and its treatment antiphlogistic, have gradually given place in the minds of many to the idea that in croupous pneumonia we have an infec-

tious disease. The natural difficulties in the way of substantiating such views have been diminished by the evidence which experimental pathology has furnished in the results of inoculation with the recently discovered micrococcus of pneumonia. Closer examination has shown, too, that only four per cent. of the cases originate in exposure to cold, the remainder being doubtful or quite independent of it. Again, as to age, it was for a long time supposed that it attacked by preference the young and strong, but while statistics show that three-fifths of all cases occur from the first to the fourteenth year, the number of cases after forty-five is double that between fourteen and forty-four; and Jürgensen agrees with Flint in noting that it is the weak rather than the strong who are attacked by preferenee.

Jürgensen has also observed at Tübingen, at least, an interesting meteorological influence upon the occurrence of pneumonia, having noted that when the rainfall exceeded the mean, the cases were fewer, while an increase followed a fall below the mean—a relation to ground moisture similar to that so long observed in the case of typhoid fever. Edlefsen had observed the same relation at Kiel. A further analogy to typhoid is observed in the effect of hygienic surroundings and peculiarities of its habitat upon the development of pneumonia, and Jürgensen called attention to the discovery by Emmerich, of the pneumonicoccus in the steerage of vessels. The question as to the contagiousness of pneumonia cannot, at present, be answered, it being very difficult to say of so widespread a disease, whether a case of apparent transmission is actually such. since it may depend upon certain coincident hygienic influences. As to whether the poison of pneumonia is single or multiple, further information on this may be expected when the study of the microparasite is completed, but from a clinical study we dare only infer its unity, the striking variations in type and localization with which we are all familiar being in no way peculiar to it, but characteristic of all infectious diseases. The poison circulating in the blood has a special preference for the lungs and pleura, but it may manifest itself also in other situations, as is shown in cases in which the disease is ushered in by other

symptoms, which give place at a later stage to those of pneumonia. Thus, Nauwerk found in the kidneys of thirteen cases dying of pneumonia, Friedländer's cocci, also incomplete zoöglea masses, in the veins; and Jürgensen discovered, in a case of pneumonia with cerebral symptoms, numerous cocci in the brain. Another peculiarity of the pneumonia poison is that its action is not gradual, as in typhus, but spasmodic, a special expression of this character being evinced in the temperature, which, in addition to the normal daily variations, exhibits numerous small variations throughout the day. It is natural to expect that treatment should be modified to adapt it to such a view of pathogenesis. Hygiene, of course, acquires great importance, but, as yet, Jürgensen admits that treatment must, for the most part, be symptomatic. Iodine has been strongly recommended as an abortive measure, but he has had no experience with it. Especially is the heart to be watched, and an intermediate degree of antiphlogosis is recommended.

In the discussion which followed, Gerhardt accepted the views of Jürgensen as to the unity of pneumonia, and ascribed the so-called complications to a single poison operating diversely, as, for example, does the poison of scarlet fever. As to treatment, he, also, as well as Rühle, recommended the expectant and symptomatic method, with constant regard to the heart. In severe cases he used quinine, and in high fever the cold bath, with simultaneous stimulation of the heart.

Fräntzel referred to the jaundice of pneumonia, a symptom imperfectly understood, which is sometimes accompanied by gastric symptoms, and at others not. He believed that the doubt regarding this symptom, especially in cases unaccompanied by gastric symptoms, was removed by the new views, since in these instances, at least, it might be regarded as hæmatogenous.

Rühle thought the infectious nature of pneumonia scarcely established because we dare not exclude altogether cold as an etiological factor. Rosenstein believed that pneumonia might be infectious, but not necessarily so; that it may be secondary to contracted kidney or to brain disease; and that treatment must vary according as the case is infectious or not. Jürgen-

sen, however, thought these secondary pneumonias are not croupous.

Nothnagel cautioned against the too free use of alcohol, which he used only as a stimulant to the heart when it required it.

It is evident from the above that as yet little has been added to our knowledge of a proper treatment of croupous pneumonia, based upon the new views as to its pathology; while we are not certain that harm may not result from the unsettling of well-established principles of treatment. It is well known that, of late, the expectant plan of treatment of pneumonia has become quite general in some sections of this country. It is also well known that the mortality has increased during this period, rather than diminished. It is the belief, too, of men of large experience that some of the fatal cases would have terminated otherwise, if active antiphlogistic measures had been used; and we are ourselves inclined to believe that the expectant plan has been too generally followed, and that better results would have obtained if bloodletting were more common in this affection. It may be true, as Rosenstein suggested, that certain cases of pneumonia may be infectious, and others true inflammations, and that the treatment should differ accordingly. We do not, however, believe that the recognition of these differences of origin and nature is sufficiently easy to justify so complete an ignoring of antiphlogistic treatment. At any rate, the expectant and restorative plan is so invariably unsuccessful in grave cases that the antiphlogistic can scarcely be more so, and we recommend a more general return to it.—*Medical News*, May 24th.

Instrument for Temporarily Closing Either Ureter.—Silverman (*Berlin Klin. Wochenschr.*) figures and describes a new instrument by which either ureter can be closed long enough to allow of unmixed urine from either kidney to be collected for examination.

The instrument consists of a metallic double catheter, with quick curve, and a window $3\frac{1}{2}$ cm. x 5 mm., near its point. The window can be closed by a shutter moved by a stilet. Within

the catheter there is contained a firm elastic catheter, which terminates in a small expansible gutta percha balloon or tampon. When collapsed, this tampon is contained within the point of the catheter.

The instrument is passed into the bladder till its beak impinges upon the posterior wall in the middle line, guided by a finger in the vagina or rectum (in men). The window is then opened, and the tampon made to expand by pouring mercury into it through the elastic catheter. By the introduction of 20 c,cm. of mercury, which weighs about 270 grms., the tampon can be filled up to the size of a goose's egg, and, guided by the finger to either side of the middle line, will by its weight effectually prevent any outflow of urine from the ureter upon that side. The bladder can be emptied and washed out through the other channel of the metallic canula, and urine from the free ureter allowed to collect for from fifteen to twenty minutes, in which time quite enough for satisfactory examination can be obtained.

Silverman had used it twenty-two times in women, and five times in men, and did not find its use attended with discomfort to the patient or followed by any evil effects.—*Centralbt. F. Chir., Glasgow Medical Journal.*

Tuberculosis of the Testis.—A laborer, aged 38, had hydrocele, cause not determined; he denied syphilis. Volkmann's operation was successfully performed; five weeks later the patient returned with a history of rigors, insomnia and loss of flesh. The testicle was then removed, and was found to show central tuberculosis, the hard tubercular mass not having yet had time to break down. A second patient, aged 31, had suffered from acute traumatic orchitis and epididymitis. Six weeks after the injury, the testicle was painful, swollen and hard; the swelling extending some distance up the cord. Chilliness and sweating were also complained of. The testicle, when removed, exhibited incipient breaking down of the tuberculous deposit centrally; while the tunica vaginalis, instead of being close and firm, closely resembled the synovial membrane

in cases of tuberculosis of the joints. In a third case, there had been chills, emaciation, loss of appetite, and swelling and pain of the testicle; the organ was found to consist almost entirely of broken-down tissue, and the tunica vaginalis had become obliterated. Dr. Gerster, who exhibited the specimens before the New York Pathological Society, remarked that in such cases the diagnosis could now be made much earlier than was formerly done, thus leading to proper treatment by extirpation; whereas it used to be the practice to let the condition remain until a fistulous opening formed in the scrotum, producing the so-called hernia testis. In the patients above mentioned, no physical signs of tuberculosis were detected in any other parts of the body; the general symptoms—rigors, sweats, &c.,—disappear on the removal of the diseased testicles.—*New York Medical Journal*, February 23rd.

The Anti-Vivisection Agitation from a Layman's Point of View.—George Augustus Sala, in his "Notes of the Week," in a late number of *The Illustrated London News*, writes:—

"The Committee of the Anti-Vivisection Society have sent me a circular referring to a meeting of the members and supporters of the Society to be held on Friday, May 9th.

"I have nothing to say myself against vivisection (when placed under proper legal restrictions), for the simple reason that for fifty years I have been in constant contact with the doctors, and have known some of the most eminent surgeons of the last and the present generations.

"I was, in early childhood, that which I once heard my mother's maid, in conversation with a friend, describe me as being 'a miserable little hobject;' and the doctors were continually doing things to me. I am, in many respects, a miserable object now, and require to be periodically patched up by the faculty. And I will say naught against vivisection, because I never yet met with a cruel doctor; and because I firmly believe medical men to be among the most humane, the most generous, the most unselfish of mankind; and I indignantly denounce the

imputation that there are any members of a noble, a high-minded, and a beneficent profession, who, actuated by no more exalted motives than their 'greed after the hidden things of the life of the flesh,' confessedly and without compunction torture dumb animals. The medical man practises vivisection (with the smallest possible infliction of pain on the animal vivisected), not because he is selfishly greedy after 'the hidden things of the life of the flesh,' but because he wants to find out what is the matter with *you*, verbose Sir or sentimental Madam; because he is striving his utmost to devise means for saving *you* from misery and anguish; for mitigating the agony of the ills that rack the joints, or fire the veins, or that 'in the deeper vitals rage.' He is no worshipper of knowledge as of an idol. He tries during his whole laborious life to learn more and more, in order that he may console and relieve and preserve suffering humanity."

Ring-Pessary Removed after Fourteen Years' Impaction.—Dr. Herbert Renshaw reports the case of a lady complaining of severe pains in the back and legs and unpleasant vaginal discharge. She was also obliged to pass her motions in the upright position, owing to the intense pain caused by any attempt to relieve the bowels in a sitting posture. On examination a smooth, raised fleshy ridge was found, running from before backward, on each side of the vagina, terminating before and behind in a rough semicircular ridge. Fourteen years previously the patient suffered from a troublesome bearing down. She consulted a "wise woman," who introduced a ring and asserted that it would never require to be removed. For many years she received great benefit from this support. The ring was removed by shelling it out from the fleshy overgrowth by picking through with the finger-nail. Half an hour after the operation all her pains disappeared. *British Medical Journal.*

CANADA

Medical and Surgical Journal.

MONTREAL, JULY, 1884.

THE ACTION OF ANTIPYRIN.

Antipyrin, an alkaloid, which is made synthetically from the Chinolin series, has recently been tried in twenty-seven cases of febrile disorders by Guttmann, of Berlin. In quantities of from one dram to one dram and a half, which are best given in two or three doses at intervals of an hour, antipyrin is a powerful and very certain antipyretic. The effects last usually five hours, and frequently much longer. The temperature slowly and gradually falls one hour after the administration of the first dose, and continues falling after the hourly doses. The fall from a dram and half, in three hourly doses, varies from 2½° to 3½° (Fah.) The duration of the fall varies from six to eighteen hours, that is before the temperature has reached the degree it had before the administration of the drug. The temperature only remains at its lowest point from one to two hours. The rest of the time is occupied in the gradual descent and subsequent ascent of the temperature. Simultaneous with the fall in the temperature, there is a decrease in the pulse rate, and generally profuse sweating. No untoward effects follow its administration with the exception that occasionally it does produce vomiting. It differs from Kairin in the following particulars :—

1. The fall of temperature is much slower from antipyrin.

2. The subsequent rise in the temperature is also slower, and on this account the ascent is never attended with rigors as it frequently is when Kairin has been given.

In many respects its anti-pyretic action more nearly resembles

quinine than it does antipyrin. It is, however, a more certain antipyretic than quinine. The dose is, at least, double that of quinine. It is best administered in capsules, on account of its disagreeable bitter taste.

TREATMENT OF CARBUNCLE.

This affection, fortunately rare with us in Canada, is exceedingly common in the large cities of Great Britain. We remember seeing one in the London Hospital recently which must have measured seven or eight inches in diameter. This was being treated simply by poultices, without incision. Mr. Hutchinson has long been opposed to the treatment of carbuncle by incision, believing that the duration of the disease is not shortened by that procedure, while the patient is subjected to some shock and often serious hemorrhage. We notice that Dr. Ashurst, of Philadelphia, also objects to incision in the treatment of carbuncle, preferring what he terms *pressure treatment.* He gives the credit for originating this method to Mr. O'Farrall, an Irish surgeon, who applied compression by means of a plaster made to cover the whole mass of carbuncle, and when suppuration began he cut a central opening for the escape of pus. Dr. Ashurst uses strips of plaster, bringing them gradually more and more inward from the margin, until a space in the centre is alone left uncovered through which the slough may find exit.

We have experience only with the treatment by incision, and with which, by the way, we have had every reason to be satisfied, although we can readily understand that in the earlier stage of the disease compression might prove of immense service. At any rate we purpose giving it a trial when occasion offers, and would ask our readers to do likewise, hoping that they will favor these pages with the results of their experience.

VOLUNTEER MEDICAL OFFICERS.

" Volunteer medical officers have now a recognized position in their regiments and definite duties and drills to superintend and men to command, and it is to be hoped that they will now accept their position with favour, and drill their men in ambu-

lance and stretcher work, thus taking their place among their working brother officers, instead of being, as is the case in many regiments, merely ornamental appendages. In several metropolitan and provincial Volunteer regiments, the bearers are intelligent, well instructed, and well drilled, and considering their few opportunities for practical work they are wonderfully efficient, and in all cases are zealous in their duties. We look upon this military ambulance work as a great advance, and we trust that the medical officers of our Volunteer army will not neglect their opportunity."—*Med. Times* (Lond.)

We are glad to see that this important department of the military service is beginning to receive here also some of the attention which it so much deserves. The 6th Fusiliers (Surgeon Jas. Bell) have recently added an ambulance corps and a full complement of regulation stretchers to their otherwise very efficient regiment. The members of the ambulance staff have been already fairly drilled under the immediate supervision of the Surgeon in charge. On two recent occasions they were called upon to do service for men who fell out from heat-stroke. Their promptitude and efficiency has been well spoken of. It would be well that this matter should be taken up by the medical officers of all our Canadian Volunteer regiments.

The utter want of adaptation of clothing to climate, as regards the uniform of our citizen-soldiers, was well shown on one of the occasions above alluded to. On the day of inspection the weather happened to be unusually warm, with that closeness of the air which often precedes a thunderstorm. The men marched in full uniform only from their armory to the parade-ground—about 20 minutes. In as many more minutes, ten men were carried off on stretchers, suffering from faintness, weakness, and dizziness; as many more felt ill, but managed to keep in the ranks. Of what value would men so equipped be for a march of any distance on a summer's day? The defects in dress and accoutrements are pretty well understood. Who will move for reform?

AN OPPORTUNITY FOR AMERICAN PATHOLOGISTS.—Under this heading the *N. Y. Medical Record* calls upon its countrymen to wake up and make haste to hunt the wary bacillus of yellow fever, or else the ubiquitous Koch will be before them. It says—

"At the banquet in Berlin, tendered to Dr. Koch on the return of the cholera commission, that eminent and successful investigator was called upon for a speech. In his response allusion was modestly made to the results of the commission's work, and the suggestion was put forth that, by a similar course of investigation, the germs of yellow fever and other infectious diseases might be found. It would be naturally inferred from the tenor of the remarks that Dr. Koch and his assistants held themselves ready to visit some part of the new world and hunt down, for example, the hypothetical parasite of yellow fever. If this duty should be assigned them, they would, no doubt, be cordially welcomed and efficiently assisted. But it would be a little odd, with our National Board of Health, and our numerous State and municipal sanitary organizations, to see a few foreigners in our midst looking for, and perhaps discovering, the germs that have so far eluded us. Yellow fever is the bane of American seaports in the summer. It interferes with our commerce, and at intervals spreads death and disaster among the people. As a country we are especially interested in finding the specific organism of this disease, if such exists. Are there no investigators among us competent, and no State or other organization willing to undertake a thorough study of the disease, using the methods adopted abroad? Or must we wait for Dr. Koch to come, capture the bacillus in a few months, and then return to be fêted and decorated with more medals at Berlin? We write this while aware that reports (whose authenticity is, however, questionable) are published to the effect that the organism of yellow fever has already been discovered.

CHOLERA.—The plague *has* spread eastward as has happened so often before. The outbreak at Toulon would seem to have been severe, and some hundreds of deaths have occurred. We also hear of its appearance in some German and Italian towns.

Will it visit America? It is reported that Koch has expressed himself strongly of opinion that it will. Let the mere mention of such a possibility cause every Board of Health, every sanitary authority, to awake to a sense of the responsibility of their positions; let action take the place of talk, and let every community prepare to set its house in order. It is useless to adduce arguments in favor of the value of cleanliness, municipal, civic, personal, and private. The difficulty is to get people to realize its necessity, and take the necessary action to ensure its accomplishment. At this time every medical man should be found lending his assistance in the direction of enforcing sanitary regulations, *coute qui coute.*

SURGERY EXTRAORDINARY.—If we are to believe the reporter of one of the New York papers, the House Surgeon of St. Vincent's Hospital in that city must be a man who likes his joke. He makes the reporter tell his readers with all gravity the following Munchausen-like story. A man had both legs crushed to pulp by an enormous weight falling upon them. The surgeon above mentioned took him in hand, removed an immense number of fragments of the comminuted bones, leaving the periosteum. All the arteries of the limbs were crushed to "tatters" from the ankle to near the knee. "I therefore," he says, "entirely removed the injured portions of these arteries and inserted very slender tubes of decalcified bone about as large as a pipe stem into the several ends and then bound them fast with catgut." The following is to be the *modus operandi* of the cure—"The ends of the arteries gradually grow over the tubes towards each other until they meet, and by that time the tubes, being of decalcified bone, and the catgut threads will have been completely absorbed!" *Credat Judæus.*

CANADA MEDICAL ASSOCIATION.—The annual meeting of the Canada Medical Association will take place at Montreal on the 25th, 26th and 27th August. The Local Reception Committee have held several meetings, and are making all necessary preliminary arrangements. It is hoped that, owing to the British Association immediately following, a larger attendance than

ever before will be obtained. Mr. Lawson Tait and other distinguished guests are expected to give addresses. We hope to publish in our next the titles of papers to be read. The usual reductions will be made by railway and steamboat companies. Any information relative to the meeting will be furnished on application to the Acting Secretary, Dr. James Bell, Beaver Hall Terrace, Montreal.

PHARMACEUTICAL ASSOCIATION, PROVINCE OF QUEBEC.—The annual meeting of the Pharmaceutical Association of the Province of Quebec was held at Quebec on the 10th June. There was a large attendance of members from all parts of the Province. The following gentlemen were elected as members of Council for the ensuing year: Messrs. H. R. Gray, A. Manson, H. F. Jackson, Edmond Giroux, sen., H. S. Evans, J. D. L. Ambrosse, P. Mathie, and F. C. Sanders. These, with the following, who remain in office in accordance with the provisions of the Quebec Pharmacy Act, constitute the Council for the ensuing year: Messrs. J. A. Harte, S. Lachance, John Kerry, and C. J. Covernton. A supplementary examination was held at Quebec on the 9th and 10th of June, when the following were successful:—*Major*—Henry Vernier, Quebec; Jules Hirtz, Montreal. *Minor*—A. E. Giguere, T. Coderre, and George Treggett. *Preliminary*—M. Bouchard and Robert Webb.

Medical Items.

—We learn that Dr. John Campbell of Seaforth, Ont., has been nominated by the Huron Medical Association to contest the Malahide and Tecumseh division at the coming election for the Medical Council. The well known abilities and sterling character of Dr. Campbell would make him a most desirable member of the Council.

—It is proposed to establish in Philadelphia a chair to be known as the S. D. Gross Professorship of Pathological Anatomy. Circulars have been issued to members of the profession and others interested, asking that subscriptions for this object be sent to Dr. R. J. Dunglison, of Philadelphia. We hope that

many in Canada will aid in the permanent commemoration of the name of one who long held the highest place amongst the surgeons of cis-Atlantic cities.

—We notice by the late papers that our friend, Mr. Chiene, the able and popular Professor of Surgery in Edinburgh University, is at present interesting himself in the very philanthropic work of erecting a Sanatorium at Market Gate, Fifeshire, to which over-worked students may resort for rest and change. From our hearts we wish him every success in this, as in all his laudable ventures.

—A singular accident is reported to have happened in connection with the insulated electric rail on the Portrush Electric Tramway. A ploughman returning from work on Thursday stood upon the rail to mount his horse, and, on applying his hands to the back of the animal, the brute fell dead, while the man was uninjured although the current of electricity must have passed throngh his body to the horse.

LOCAL TREATMENT OF ERYSIPELAS.—An epidemic of fifty cases of erysipelas gave Polyanyi an opportunity of making comparative observations of different methods of treatment. The best results were given by applications of freshly-prepared sulphurous acid solution, made carefully every two hours over every part of the affected surface. J. Andeer prefers a fifty to eighty per cent. ointment of resorcin.— *Wiener Med. Presse.*

A HEART MURMUR HEARD IN UTERO.—Dr. E. C. Cordell read a paper before the Medical and Chirurg. Faculty of Maryland (*Med. Record*, May 3), upon the absence of one of the segments of the mitral valve of a child who had died cyanotic one hour after birth. Some hours before delivery a systolic murmur had been recognized, which was supposed to be located at the mitral orifice. The autopsy revealed the lesion mentioned above. The condition appeared to be due to defect in development, and not to pathological causes; there was not any other abnormality.

WHAT IS IN A NAME.—A doctor with an Arabo-Hindustani name settled in one of the suburbs of Paris. In a short time he had a large run of wealthy patients. The police sent an

officer to inquire about the diploma of the mysterious practitioner. The doctor received the officer very politely, and smilingly showed him his full certificates and diploma from the University of Paris. "But," he said to the officer, "you will oblige me if you do not speak about this affair, for I would lose all my patients in a short time if they should know that I am a regular Parisian physician."

TOBACCO AS AN ANTIZYMOTIC.—There is a popular notion that the use of tobacco is in some degree a protective against the infectious diseases. In the *Montpellier Médical*, quoted in the *Bulletin Général de Therapeutique*, Dr. Pecholier supports this belief, saying that he considers tobacco an energetic parasiticide capable of acting upon microxymes and microbia, and that, while he thinks its abuse liable to produce well-marked effects on man, he is nevertheless convinced that it is capable of rendering important service in protecting him against epidemic and contagious diseases. He lays particular stress on the immunity against phthisis acquired by workers in tobacco.

A WINK AS GOOD AS A NOD.—Dr. de la Pommerais was executed in June, 1864, for a murder of the Palmer type. On the night before his execution he was visited by Surgeon Velpeau, who, after a few preliminary remarks, informed him that he came in the interest of science, and he hoped for Dr. de la Pommerais's co-operation. "You know," he said, "that one of the most interesting questions of physiology is as to whether any ray of memory, reflection or real sensibility survives in the brain of a man after the fall of the head." At this point the condemned man looked somewhat startled; but professional instincts at once resumed their sway, and the two physicians calmly discussed and arranged the details of an experiment for the next morning. "When the knife falls," said Velpeau, "I shall be standing at your side, and your head will at once pass from the executioner's hands into mine. I will then cry distinctly into your ear, 'Count de la Pommerais, can you at this moment thrice lower the lid of your right eye, while the left remains open?" The next day, when the great surgeon reached the condemned cell, he found

the condemned man practicing the sign agreed upon. A few minutes later the guillotine had done its work, the head was in Velpeau's hands and the question put. Familiar as he was with the most shocking and gastly scenes, he was almost frozen with terror as he saw the right lid fall, while the other eye looked fixedly at him. "Again!" he cried frantically. The lids moved, but they did not part. It was all over.—*Med. Review.*

—Mellin's Food for Infants and Invalids.—A recent analysis by Mr. G. W. Wigner, the President of the Society of Public Analysts of England, throws considerable light, not only on the composition, but on the physiological action of this popular preparation. It appears that it contains nearly 87 per cent. of dextrine, maltose, etc., soluble in cold water. As Mr. Wigner points out, it is not a mere starch or sugar food, but a soluble preparation, containing those nitrogenous and phosphatic principles which contribute largely to the growth of bone and tissue in young children. Being thoroughly malted, it is not only readily digestible itself, but actually assists in the digestion of milk and other foods with which it is mixed. It must of necessity be of great value in the case of feeble infants who cannot digest ordinary starchy foods. Mr. Wigner's analysis has evidently been performed with great care, and is of much interest."—*British Medical Journal*, May 3, 1884.

—The following editorial notice we clip from the English *Medical Press and Circular* of April 2nd, 1884:—"The undoubted advantages of malted preparations as articles of food have been so universally demonstrated that each candidate for professional favour, if carefully compounded, is welcomed as a useful addition to the physician's resources. In this connection a Canadian chemist, Mr. Hazen Morse, has produced a compound of pepsine and dry extract of malt, which combines the needed qualities of efficiency as a digestive agent and nutritive value as a food, and which, taken in doses of ten grains before meals, acts as a most beneficial and certain promoter of rapid digestion, and so ensures complete assimilation. In those forms of diarrhœa due to undigested food in the intestinal canal, from which young children are specially prone to suffer, this preparation acts almost as a specific; and regarded as a useful therapeutical aid to health, we can confidently recommend it for general use."

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GEORGE ROSS, A.M., M.D., and T. G. RODDICK, M.D.

TABLE OF CONTENTS.

		PAGE
ORIGINAL COMMUNICATIONS—		
Clinical Lectures—On a Case of Exophthalmic Goitre	*Dr. James Stewart*	705
On the Antiseptic Treatment of Wounds	*Dr. F. J. Shepherd*	712
Sciatica, with complete loss of sensation	*Dr. J. Campbell*	719
CORRESPONDENCE—		
Letters from Berlin—Virchow, Von Frerichs, &c.,	*W. O.*	721
Surgical Notes—Bergmann's Klinik	*R. J. B. H.*	729
REVIEWS—		
The Dissector's Manual	*Clarke and Lockwood*	733
Guide to Diseases and Injuries of the Eye and Eyelids	*Dr. L. H. Tuswell*	734
Treatment of Diseases of the Rectum and Anus	*Dr. C. B. Kelsey*	735
Influence of the Mind upon the Body in Health and Disease	*Dr. D. H. Tuke*	736
The Field of Disease: A Book of Preventive Medicine	*Dr. B. W. Richardson*	738
A Study of the Bladder during Parturition	*Dr. J. H. Croom*	739
A Manual of Obstetrics	*Dr. A. F. A. King*	740
BOOKS AND PAMPHLETS RECEIVED		740
SOCIETY PROCEEDINGS—		
MEDICO-CHIRURGICAL SOCIETY OF MONTREAL:		
Pathological Specimens: Radius and Skull; Syphilitic Teeth; Hemorrhage into the Cerebellum; Brain of a Monkey; Skull and Brain of an Idiot—Remarks on the latter by Dr. Henry Howard		741–747
SELECTIONS—		
Bandy-Legged Irish Children—Case of Gluteal Aneurism—Transmission of Tuberculosis—Use of Forceps in Breech Presentations—Duration of Menstrual Hemorrhage—Recent Views on the Origin and Nature of Pneumonia—Instrument for Temporarily Closing either Ureter—Tuberculosis of the Testis—The Anti-Vivisection Agitation from a Layman's Point of View—Ring-Pessary Removed after Fourteen Years' Impaction		748–759
EDITORIAL—		
The Action of Antipyrin—Treatment of Carbuncle—Volunteer Medical Officers—An Opportunity for American Pathologists—The Cholera—Surgery Extraordinary—Canada Medical Association—Pharmaceutical Association, Province of Quebec		760–765
MEDICAL ITEMS		765–768

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For Index to Advertisements—See Page XXI.

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A specialty with WM. R. WARNER & CO.

A LONG and practical experience gained in the Retail Drug Business, and a thorough knowledge of Practical Pharmacy, in connection with our present daily correspondence and intercourse with medical practitioners throughout the country, enables us to understand exactly the requirements for an Office Practice and Dispensing Department. We supply everything relating thereto, comprising Chemical and Pharmaceutical Preparations, Drugs, (whole and powdered,) and all the recent Medical Appliances for which our Philadelphia manufacturers are so famous. All drugs are carefully selected, chemicals pure and pharmaceutical preparations officinal and standard in strength. We guarantee satisfaction to those favoring us with their orders.

Drug and Hospital Outfits furnished at prices ranging from $500.00 to $5000.00.

Physicians' Outfits furnished at prices ranging from $50.00 to $200.00.

WARNER'S MEDICAL CABINET FOR PHYSICIANS.

PRICE, $125.00

This is an ornamental piece of furniture for the office, containing an assortment of eighty-three of the most important medicines and useful articles, in bottles with indestructable glass labels. It has also a series of drawers for keeping instruments, powder-papers, blank labels, spatulas, &c. and will be found of the greatest convenience to physicians when it is desirable to dispense their own medicines.

Estimates and all information relating to the above cheerfully given.

WM. R. WARNER & CO.

WHOLESALE DRUGGISTS AND CHEMISTS,

MANUFACTURERS OF

Warner & Co.'s Officinal and Ready-Made Pills as a Specialty.

PHILADELPHIA AND NEW YORK.

The following well known houses in the Dominion have stock or will supply any of Warner & Co.'s Standard Preparations.

KERRY, WATSON & CO., Montreal.	P. WINER & CO., - Montreal.
LYMAN SONS & CO., "	LYMAN SONS & CO., Toronto.
H. SUGDEN EVANS & CO. "	ELLIOT & CO., Toronto.
KENNETH, CAMPBELL & CO. "	LONDON DRUG COMPANY, London.
H. HASWELL & CO., "	R. W. McCARTY, Halifax, N. S.
R. J. DEVINS, "	BROWN & WEBB, Halifax, N. S.

WARNER & CO.'S

PIL: CHALYBEATE

3 Grains. Dose.—1 to 4 Pills.

(BLAUD.)

Ferri Sulph. Fe_2SO_4 } = Ferri Carb. $FeCO_3$
Potass. Carb. K_2CO_3 } = Potass. Sulph. K_2SO_4

As Prepared by WM. R. WARNER & CO., Chemists,

PHILADELPHIA.

The above combination which we have successfully and scientifically put in pill form produces when taken into the stomach, Carbonate of the Protoxide of Iron, (Ferrous Carbonate) in a quickly assimilable condition.

This Pill contributed to make the reputation of Niemeyer, and the following language, which speaks without comment, is taken from his TEXT BOOK ON THE PRACTICE OF MEDICINE.

PROF. NIEMEYER says: "For more than twenty years I have used these pills almost exclusively in Chlorosis, and have witnessed such brilliant results from them in a large number of cases that I have never needed any opportunity to experiment with other articles. At Madgeburg and Greifswald I often had to send my recipe for the pills to a great distance, my good fortune in the treatment of Chlorosis—to which, by-the-by, I owe the rapid growth of my practice—having given me great repute as the possessor of a sovereign remedy against that disease."

The dose of Pil: Chalybeate is from 1 to 4 at meal times and is recommended and successfully used in the treatment of Pulmonary Phthisis or Consumption, Anæmia and Chlorosis, Caries and Scrofulous Abscesses, Chronic Discharges, Dyspepsia, Loss of Appetite, etc.

☞ *The physician may see that he is obtaining exactly what he prescribes, by ordering in bottles containing 100 each.*

CAUTION.—Specify WARNER & Co., and see to the special marks and Autograph on wrapper. The coating is very soluble, and is colored a delicate pink.

Pills can be safely sent by mail—discount for quantities.

PREPARED BY

William R. Warner & Co.

MANUFACTURERS OF

BLE COATED PILLS AS A SPECIALTY.

NEW PRINCIPLE FOR THE ASSIMILATION OF FAT

HYDROLEINE "HYDRATED OIL."

"HYDROLEINE" may be described as partially digested oil, which will nourish and produce increase in weight, in those cases where oils or fats, not so treated, are difficult or impossible to digest. In CONSUMPTION and other WASTING DISEASES, the most prominent symptom is *emaciation*, of which the first is the starvation of the fatty tissues of the body, including the brain and nerves. This tendency to emaciation and loss of weight is arrested by the regular use of HYDROLEINE. The ordinary so-called emulsions of Cod Liver Oil and other fats, *whether pancreatised or not* merely remain in the form of a coarse mechanical mixture for a short time after agitation. The digestion of oil, having in no sense been artificially produced, still devolves upon those functional powers, the deficiency of which is the most prominent symptoms in these cases.

"A great misconception as to the real characteristics of a true pancreatic emulsion has been entertained by many, and but few appear to have studied the different aspects presented by such an emulsion as is produced on fat by the energetic action of pure soluble pancreatin, as contrasted with the coarse mechanical mixtures of oil or fat and water, which are commonly supposed to represent this function of fermentative digestion.

Some seem to think that if a bottle of oil is shaken up with the compounds sold as the active principle of the pancreas, and a yellowish cloud is diffused for a time through the oil, an emulsion has been obtained. So it has, but not the true pancreatic emulsion, which forms an integral portion of the process by which fats are digested and assimilated. From the unvarying result of many hundred trials with the pure, active principles of healthy pancreatic fluid, taken at the time of digestion, I am perfectly convinced that no valuable result has been attained, unless the emulsion formed is as highly refractive of light as milk. The color may vary, according to the oil or fat used, from a far whiter fluid than the densest milk to the opacity and color of Devonshire cream, but unless at least the equivalent of the density of the best milk is produced in oil, when a third of water is held in suspension, no real pancreatic emulsion has been formed.

The mere mechanical mixture formed by common pancreatin is rarely better or more persistent than may be produced by rubbing up oil or fat with a solution of mucilage, or by a warm application of dissolved gelatin, shaken with oil until it becomes cold.

The first essential towards the digestion of fats or oils in the human body is that it shall assume the state of the very finest and most permanent emulsion, and this is only known to be attained when the oil and water is perfectly opaque, from the minuteness of the globules. This is the first function of the pancreatic emulsifying principle, and by this alone can we be certain that it possesses its proper fermentative activity."—*Prof. Bartlett's Treatise.*

(HYDRATED OIL)

HYDROLEINE

(WATER AND OIL.)

The efficacy of this Preparation is **NOT CONFINED** to cases of **CONSUMPTION,** as from its valuable tonic effect on the nervous system, in addition to its special stimulating action on the organs concerned in the production of Fat in the body, *it causes* [illegible] *ed increase in weight in persons of naturally thin habit, who do not present any evidence of disease.*

The principles upon which this discovery is based have been described in a treatise on "THE DIGESTION AND ASSIMILATION OF FATS IN THE HUMAN BODY," by H. C. BARTLETT, PH. D., F.C. S., and the experiments which were made, together with cases illustrating the effect of Hydrated Oil in practice, are concisely stated in a treatise on "CONSUMPTION AND WASTING DISEASES," by G. OVEREND DREWRY, M.D., of London.

In these treatises, the Chemistry and Physiology of the Digestion of Fats and Oils is made clear not only by the description of a large number of experiments scientifically conducted, but by cases in which the deductions are most fully borne out by the results.

Copies of these valuable works will be sent free on application.

FORMULA OF HYDROLEINE.

Each dose of two teaspoonsful, equal to 120 drops, contains:

Pure Oil	80 *m* **(drops.)**
Distilled Water	35 "
Soluble Pancreatin	5 **grains.**
Soda	½ "
Boric Acid	½ "
Hyocholic Acid	1-20 "

DOSE.—Two teaspoonsful alone, or mixed with twice the quality of soft water, to be taken thrice daily with meals.

Unlike the ordinary preparation of Cod-Liver Oil, it produces no unpleasant eructation or sense of nausea, and should be taken in such very much smaller doses, according to the directions, as will insure its complete assimilation: this, at the same time, renders its use economical in the highest

FOR CONSUMPTION AND WASTING DISEASES.

HYDROLEINE (HYDRATED OIL)

FOR DYSPEPSIA, INDIGESTION, ETC.,

MALTOPEPSYN.

Having for the past three years published the names of most of the leading physicians of Canada endorsing both these remedies, I will therefore now only give the names of a few of the profession, and will add the opinions of some of the leading Druggists throughout the Dominion.

JAS. H. RICHARDSON, M. D.,	TORONTO.	JOHN REDFIELD, M. D.,	MONTREAL.
J. ALGERNON TEMPLE, M. D.,	"	D. C. MCCALLUM, M. D.,	"
J. H. MCCOLLUM, M. D.,	"	F. G. RODDICK, M. D.,	"
JOHN E. KENNEDY, M. D.,	"	GEO. ROSS, M. D.,	"
O. S. WINSTANLEY, M. D.,	"	JOHN T. FINNIE, M. D.,	"
J. E. GRAHAM, M. D.,	"	GASPARD ARCHAMBAULT, M. D.,	"
J. H. BURNS, M. D.,	"	W. B. BURLAND, M. D.,	"
CHAS. WM. COVERNTON, M. D.,	"	CASEY A. WOOD, M. D.,	"
		A. LAPTHORNE SMITH, M. D.,	"

FROM LEADING CHEMISTS AND DRUGGISTS.

144 ST. LAWRENCE MAIN ST., MONTREAL, NOV. 18, 1880.

I beg to say that Hydroleine is increasing in favor with the medical profession. It digests easily and in most cases rapidly, and brings up the weight of the patient. To prove which, several physicians have weighed their patients before beginning the remedy. My sales this month are larger than ever.

HENRY R. GRAY, Chemist.

TORONTO, AUG. 15, 1881.

With reference to your Maltopepsyn, I would say I never sold any preparation of the kind which seemed to give such universal satisfaction both to physicians and patients.

The increasing sales with the testimony of numbers who have obtained marked benefit from its use, show that Hydroleine is a great success.

H. J. ROSE, Pharmacist.

TORONTO, JULY 20, 1881.

We have much pleasure in informing you that the sale for Hydroleine and Maltopepsyn is increasing greatly, both over counter and in dispensing. Many people who cannot take Cod Liver Oil take the Hydroleine with great benefit.

E. HOOPER & CO., Chemists and Druggists.

MONTREAL, AUG. 15, 1881.

We have very favorable news in reference to Hydroleine and Maltopepsyn. Their sale is increasing, and we have heard through medical men who have prescribed them that they both give entire satisfaction.

LAVIOLETTE & NELSON, Pharmacists.

MONTREAL, AUG. 15, 1881.

I have much pleasure in saying that numbers of my customers express themselves highly satisfied with the action of both Hydroleine and Maltopepsyn, and in consequence I find the sales increasing.

J. A. HARTE, Chemist and Druggist.

---

444 QUEEN ST. WEST, TORONTO, MARCH 4, 1882.

I have much pleasure in informing you that the sale of Hydroleine and Maltopepsyn is rapidly increasing, and the very best of results invariably follow their use. Leading medical men are ordering them freely, which fact is sufficient guarantee of their being reliable preparations.

HARRY SHERRIS.

171 KING ST. EAST, TORONTO, FEBRUARY 3, 1882.

I feel it a duty to the public and yourself to communicate to you the very satisfactory results affected by your Maltopepsyn.

JOSEPH DAVIDS & CO.

---

382 & 630 QUEEN ST., 324 SPADINA AVE., TORONTO, FEB., 1882.

I have been selling your Hydroleine and Maltopepsyn for some time past, and find it gives universal satisfaction.

JOSIAH GREEN.

---

243 YONGE ST., TORONTO, 1882.

I have sold Hydroleine and Maltopepsyn since their introduction, and must say that they have given entire satisfaction.

CHAS. W. HOWARTH.

BELLEVILLE, FEBRUARY, 1882.

We have sold both remedies, and find them spoken of very favorably by both the Medical Profession and the Public.

We can safely recommend them to parties needing such remedies.

L. W YEOMANS & CO.

BELLEVILLE, ONT., FEBRUARY, 1882.

In recommending Hydroleine and Maltopepsyn, we endorse the opinions of many of our customers who have used both.

JAS. CLARKE & CO.

BELLEVILLE, FEBRUARY, 1882.

I believe Hydroleine gives general satisfaction. I have also received very good reports from the use of Maltopepsyn in cases where other preparations have failed.

A. L. GEEN.

BELLEVILLE, ONT., FEBRUARY 7, 1882.

I have much pleasure in recommending your preparations of Maltopepsyn and Hydroleine, as they have given entire satisfaction wherever they have been used.

R. TEMPLETON.

BELLEVILLE, FEBRUARY 8, 1882.

I have much pleasure in assuring you of the general usefulness of your Hydroleine, and the confidence bestowed upon it by those who have used it. One customer says, respecting his child troubled with Chronic Bronchitis, "Nothing answers him so well; he thrives upon it."

W. R. CARMICHAEL.

BROCKVILLE, ONT., FEB. 13, 1882.

We have much pleasure in stating that for the past two years we have sold Hydroleine. It has given satisfaction, as the sales of it have been considerable, and we have no complaints.

ALLAN, TURNER & CO.

LONDON, ONT., NOV. 24, 1881.

I have much pleasure in informing you that the sale for Hydroleine and Maltopepsyn is increasing greatly, both over the counter and in dispensing. Many people who cannot take the Cod Liver Oil take Hydroleine with great benefit.

W. T. STRONG.

OWEN SOUND, JAN. 6, 1882.

The sale of your preparations, Hydroleine and Maltopepsyn, has been very large, giving satisfaction wherever used.

ROBERT WIGHTMAN.

WINGHAM, ONT., JAN. 11, 1882.

I have used Hydroleine and Maltopepsyn for over a year, and have the satisfaction of knowing that I can safely and confidently recommend them to my customers,

W. T. BRAY.

NEW REMEDY FOR TEETHING INFANTS

And Adults Suffering from Nervousness, Headache, Etc.

MORSE'S

Glycerole of Celery Compound

EACH FLUID DRACHM CONTAINS:

CELERY SEED,	4 GRAINS.
CATNIP HERB,	.5 GRAINS.
CHAMOMILE,	2 GRAINS.

Dose for Teething Infants, from 2 to 60 Drops, according to age.
For Adults, from 1 to 2 teaspoonfuls.

Celery Compound is a *safe* and pleasant substitute for opium and other powerful drugs, as has been proven by many physicians, and also at the Infant's Home. See following letter:—

INFANT'S HOME AND INFIRMARY.

HAZEN MORSE, ESQ., *Toronto*, 29th December, 1882.

Dear Sir,—I must thank you for the bottles of Celery Compound. I have used it especially with the teething infants, and have found it a certain remedy for feverishness and every form of indigestion, and for the weak and sickly ones it was invaluable as a tonic, and I shall have the greatest pleasure in recommending its use to everyone. Wishing you every success, I beg to remain, yours very respectfully,

M. WHITE, *Head Nurse*.

It is not necessary to speak of the advantages obtained by substituting Celery Compound for opium, as they will be at once apparent to every physician. I would call attention to the following notice, taken from the Toronto *Evening News*, March 7, 1883:

THE DEADLY SOOTHING SYRUP.

The Drugs with which many Little Babies are Poisoned.

Cincinnati Enquirer.

The recent death in St. Louis from the injudicious administration of a certain soothing syrup to two infants (twins) has aroused attention to the danger attending the use of opiates by mothers and nurses to quiet young babies. In this case the medicine was given every day for a week, according to the testimony of one witness. The children, it is supposed, became saturated with the opiate. R. Harger, a St. Louis Chemist said there was no opium in the sample bottle of soothing syrup furnished him, but that an ordinary bottle of the same stuff bought by him he found four grains of morphine to the ounce. The stuff is the more dangerous that those using it are not careful to shake the bottle, and the morphine floats on top. Another comes from the fact that the appetite for opium grows rapidly, and the dose which satisfied the child to-day is not enough for to-morrow, and it must be increased. If the stuff is in the house it is difficult to prevent nurses from using it surreptitiously. A careless person can easily make a mistake through inattention, and not be aware that an overdose has been taken until it is too late.

"There are cases," said Dr. T. C. Minor, "of poisoning from the use of soothing syrup happening occasionally in this city. In the return to the health board there is a blank for 'immediate cause of death,' and another for 'remote cause of death.' I remember, it seems to me, at least three cases while I was health officer, where the immediate cause of death was stated to be the use of soothing syrup. This medicine contains considerable opium. I do not think opium should be given in any form to a young infant, except where the physicians deem it necessary, and then only under his direction. In cases of colic, which is the distention of the intestines by gas, warm teas will give the necessary relief, and are entirely safe. Paregoric is a safer thing than soothing syrup, but there should be no opiates administered to quiet a child. There is always danger that it will cause congestion of the brain. Some classes of congestion of the brain reported in young children are the result of administering soothing syrup, or some other opiate. It is more difficult to rally a child from the effects of an overdose of opiate than an adult."

HAZEN MORSE,

SOLE PROPRIETOR,

International Bridge, Ontario, and Buffalo, N. Y.

MALTINE.

MALTINE is a concentrated extract of Malted Barley, Wheat and Oats. In its preparation the temperature does not exceed 150 deg. Fahr., thereby retaining all the nutritive and digestive agents unimpaired. Extracts of Malt are made from Barley alone, by the German process, which directs that the mash be heated to 212 deg. Fahr., thereby coagulating the Albuminoids and almost wholly destroying the starch digestive principle, Diastase.

OBSERVATIONS ON THE DIGESTIVE FERMENTS AND THEIR THERAPEUTICAL USES. By WILLIAM ROBERTS, M.D., F.R.S., Physician to the Manchester Royal Infirmary, and Professor of Clinical Medicine to Owens's Medical College:—

"If properly prepared, Malt Extracts are rich in Diastase, and have a high power in digesting starchy matters. But you will be surprised to learn, as I was, that a large proportion of the Malt Extracts of Commerce have no action on starch. This is owing to a high temperature having been used in their preparation. Any heat above 150 deg. Fahr. is destructive to Diastase in solution, so that if the Extract be evaporated, as is directed by the German Pharmacopœia, at a temperature of 212 deg. Fahr., it is necessarily inert on starch. Out of fourteen trade samples of Malt Extract examined by Messrs Dunston and Dimmock, *only three* possessed the power of acting on starch. These brands were MALTINE, Corbyn, Stacey & Co.'s Extract, and Keppler's Malt Extract."—*British Medical Journal.*

FOOD FOR THE INVALID. By J. MILNER FOTHERGILL, M.D., Senior Assistant Physician to the Victoria Park Chest Hospital, London, England, &c.

"The action of the saliva upon the starch is to quickly convert it into sugar. Consequently, as sugar is soluble, this leaves the nitrogenised portion of the flour to be readily acted upon in the stomach. When the saliva is defective in an infant, or at least insufficient to produce the conversion of starch into sugar, it is now customary to give the infant Maltine. Maltine is a sweet molassses sort of thing, which can be added to the baby's food a brief period before it has to be taken, for the conversion is quick. The starch being thus largely converted into sugar, the digestive act in the stomach goes on without painful efforts. The treatment of dyspepsia in adults is carried out in precisely the same principles, and baby's food and Maltine are equally good for them."

PROFESSOR JOHN ATTFIELD, Ph.D., F.R.S., F.I.C., Professor of Practical Chemistry to the Pharmaceutical Society of Great Britain, in writing on Malt preparations, states as follows:—

"In comparison with the Alcoholic Malt Extracts, Maltine is about *ten times* as valuable as a *flesh former*; from *five to ten times* as valuable as a *heat producer*; and at least *five times* as valuable as a *Starch Digesting Agent*. It contains unimpaired, and in a highly concentrated form, the whole of the valuable materials which it is possible to extract from either Malted Wheat, Malted Barley, or Malted Oats."

PROFESSOR R. OGDEN DOREMUS, M.D., LL.D., Professor of Chemistry and Toxicology, Bellevue Hospital Medical College, New York, writes as follows, viz.:—

"Maltine is superior in *therapeutic and nutritive value to* any Extract of Malt made from Barley alone, or to any other preparation of one variety of grain. It is nutritive to every tissue of the body, from bone to brain."

MALTINE is prescribed by the most eminent members of the Medical Profession in the United States, Great Britain, India, China and the English Colonies, and is largely used at the principal Hospitals in preference to any of the Extracts of Malt.

☞ We will forward gratuitously a 1-lb. bottle of any of the preparations of Maltine to Physicians who will pay the express charges. Send for our 28-page Pamphlet on Maltine and its combinations.

THE MALTINE MANUFACTURING COMPANY,

JOHN CARNRICK, President.

(OF REED & CARNRICK, MANUFACTURING CHEMISTS AND PHARMACISTS,)

NEW YORK.

Canada Branch: H. P. GISBORNE, 10 Colborne Street, TORONTO.

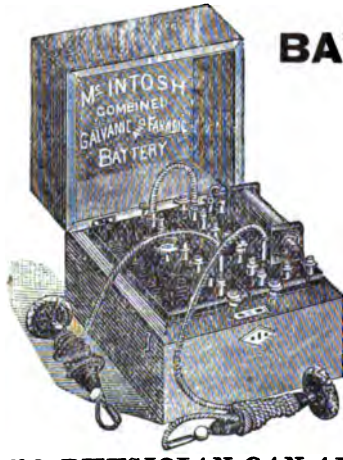
For Sale by all Druggists throughout the Dominion.

BUY THE BEST!

Highly Recommended by the Medical Faculty of both America and Europe, and adopted by the United States Government. More of them sold than any other Battery in the World.

McINTOSH

COMBINED GALVANIC AND FARADIC



BATTERY.

☛ The First and only

PORTABLE BATTERY

ever invented which gives both the Galvanic and Faradic Current, thus combining two distinct Batteries in one case.

NO PHYSICIAN CAN AFFORD TO BE WITHOUT ONE.

This celebrated Battery is constructed on an improved plan. The zincs and carbons are fastened to hard rubber plates in sections of six each; this manner of connecting brings the plates nearer together than in any other battery, thus giving less internal resistance. The rubber plate or cover will not warp or break, and is not affected by the fluid.

The cells are composed of one piece of hard rubber, and are made in sections of six each with a drip-cup, thus one section can be handled, emptied and cleaned as easily and quickly as one cell.

The fluid cannot spill or run between the cells, and there is no danger of breaking as with glass cells. The drip-cup is to receive the elements when the battery is not in use. The Faradic coil is fastened to the hard rubber plate or cover.

The rubber plate to which the zincs and carbons are attached is securely fastened over the cells when not in use, making it impossible for any of the fluid to be spilled in carrying.

An extra large cell (with a zinc and carbon element) is added to the combined batteries for the purpose of producing the Faradic current. This cell gives as much power as is ever needed, and avoids exhausting the current from the Galvanic cells.

Our Batteries weigh less, occupy less space, give a current of greater intensity and quantity than any other Battery manufactured. For simplicity of construction they cannot be surpassed, and any person reading our directions will have no trouble in operating them.

This is the only Battery in which the zinc and carbon plates can be kept clean and always in order by simply rinsing them.

All the metal work is finely nickel-plated and highly polished, and every part is put together so that it can be easily replaced by the operator.

We have the most complete line of electrodes yet offered to the profession. We also manufacture various styles of Table and Office Batteries, Bath Apparatus, &c., &c. Our manufacturing facilities are the largest of the kind in America, and we employ none but skilled mechanics, and men of scientific experience.

Our Illustrated Catalogue, a handsome book giving full description of all our goods, and other valuable information, sent free on application.

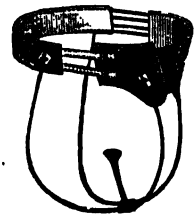
McIntosh Galvanic & Faradic Battery Co.,

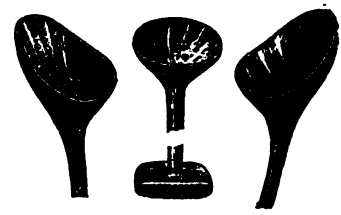
192 & 194 JACKSON ST., CHICAGO, ILL.

Or, **ELLIOTT & CO., Chemists, 3 Front St., TORONTO,**

And **F. GROSS, 682 to 690 Craig Street, MONTREAL,**

WHOLESALE AGENTS FOR CANADA.





DR. McINTOSH'S

NATURAL UTERINE SUPPORTER

No Instrument has ever been placed before the Medical Profession which has given such Universal Satisfaction.

Every Indication of Uterine Displacements is met by this combination: Prolapsus, Anteversion, Retroversion and Flexions are overcome by this instrument when others fail. This is proven by the fact that since its introduction to the profession it has come into more general use than all other instruments combined.

Union of External and Internal Support.—The abdomen is held up by the broad morocco leather belt with concave front and elastic straps to buckle around the hips. The Uterine Support is a cup and stem made of highly polished hard rubber, very light and durable, shaped to fit the neck of the womb, with openings for the secretions to pass out, as shown by the cuts. Cups are made with extended lips to correct flexions and versions of the womb.

Adaptability to Varying Positions of the Body.—The cup and stem are suspended from the belt by two soft elastic Rubber Tubes, which are fastened to the front of the belt by simple loops, pass down and through the stem of the cup and up to the back of the belt. These soft rubber tubes being elastic, adapt themselves to all the varying positions of the body, and perform the service of the ligaments of the womb.

Self-Adjusting.—One of the many reasons which recommend this Supporter to the physician is that it is self-adjusting. The physician, after applying it, need have no fear that he will be called in haste to remove or readjust it, (as is often the case with rings and various pessaries held in position by pressure against the vaginal wall), as the patient can remove it at will, and replace it without assistance.

It can be worn at all times, will not interfere with nature's necessities, will not corrode, and is lighter than metal. It will answer for all cases of Anteversion, Retroversion, or any Flexion of the womb, and is used by the leading physicians with unfailing success, even in the most difficult cases.

Our Reduced Prices are, to Physicians, $7.00; to Patients, $10.00.

Instruments sent by mail at our risk, on receipt of price. with 35 cents added for Canadian postage; or we can send by express, C. O. D.

Physicians in the Dominion can obtain these instruments at above prices from

F. GROSS, 682 & 690 Craig Street, MONTREAL,

Or ELLIOTT & CO., Chemists, 3 Front Street, TORONTO.

CAUTION.—We call particular attention of Physicians to the fact, that unscrupulous parties are manufacturing a worthless imitation of this Supporter, and some dishonest dealers, for the sake of gain, are trying to sell them, knowing they are deceiving both Physician and patient.

Persons receiving a Supporter will find, if it is genuine, the directions pasted in the cover of the box, with the head-line, "DR. L. D. McINTOSH'S NATURAL UTERINE SUPPORTER;" a cut on the right, showing the Supporter and on the left its application, also the *fac-simile* Signature of DR. L. D. McINTOSH. Each pad of the abdominal belt is stamped in gilt letters, DR. McINTOSH'S NATURAL UTERINE SUPPORTER CO., CHICAGO, ILL. Each box also contains our pamphlet on "DISPLACEMENTS OF THE WOMB," and an extra pair of RUBBER TUBES.

DR. McINTOSH NATURAL UTERINE SUPPORTER CO.,

192 & 194 JACKSON ST., CHICAGO, ILL.

Our valuable pamphlet, "Some Practical Facts about Displacements of the Womb" will be sent you free on application.

JUST RECEIVED, direct.

TROMMER'S MALT EXTRACT AND PREPARATIONS.
MALTINE AND PREPARATIONS.
WYETH'S EXTRACTS AND ELIXIRS.
WARNER'S SUGAR-COATED PILLS.
PARKE, DAVIS & CO.'S CASCARA CORDIAL.
" " " DESICCATED BLOOD.
BEEF PEPTONOIDS.
BENGER'S LIQUOR PANCREATICUS, &c.
VALENTINE'S MEAT JUICE.

HENRY R. GRAY,

Pharmaceutical Chemist,

[ESTABLISHED 1859.]

144 ST. LAWRENCE MAIN STREET, MONTREAL.

DR. WADSWORTH'S

UTERINE ELEVATOR.

Made of Soft Indiarubber, *without Lead*, unirritating, of easy application, and unfailingly keeps the womb in its natural position. The best Pessary ever invented. So say thousands of Physicians from Canada to Texas.

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McGILL UNIVERSITY, MONTREAL

FACULTY OF MEDICINE.

SUMMER SESSION, 1884.

The Ninth Summer Session of the Faculty of Medicine will begin on the 12th of April, and continue 12 weeks.

The Classes are chiefly practical and demonstrative, and are designed to supplement and extend the teaching of the regular Winter Session.

The records of qualifications of candidates for the degree show that most of the senior students now take either one or two Summer Sessions, and this is regarded by the Faculty as the best indication that the extension of its work in this direction meets a real want, and is duly appreciated.

During the past Session there was an attendance of between 50 and 60 students, including several from other schools, who are received on the same terms and have all the advantages of regular students.

The special advantages of attendance upon a Summer Session are:—

(1) The benefit derived from the practical and demonstrative classes.

(2) Dresserships and Clinical Clerkships are more easily obtained at the Hospitals, and the student has more time at his disposal to follow up the cases.

(3) Cases of Midwifery are obtained in greater number at the Lying-in Hospital.

(4) Systematic study can be carried out more effectively than at home.

The advantages offered by the City of Montreal for the practical study of Medicine and Surgery are unequalled in the Dominion. In the wards of the General Hospital there is always—and more particularly in the summer months, when navigation is opened—a large collection of interesting medical and surgical cases. In the out-door department there is a daily attendance of between 60 and 70 patients, which affords excellent instruction in Minor Surgery, routine medical practice, and Diseases of Children. The Eye and Ear Department will afford to the student an opportunity of studying practically, under skilled direction, these important branches. At the University Dispensary there will be demonstrations on Gynæcology, on Diseases of Children, and on Diseases of the Skin, and of the Nervous System.

Dresserships and Clinical Clerkships may be obtained on application to the Attending and Out-door Physicians.

The Faculty has much pleasure in announcing the following prospectus:—

I. CLINICAL INSTRUCTION, which will comprise:—

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B. Weekly Clinics in Theatre on Cases of:—1. General Surgery: Drs. Roodick and Shepherd. 2. General Medicine: Dr. R. L. Macdonnell. 3. General Medicine: Drs. Wilkins and Ross. 4. Gynecology: Dr. Gardner. 5. Diseases of Throat: Dr. Major. 6. Diseases of the Nervous System, at the College: Dr. Stewart. 7. Diseases of Children, at the College: Dr. Blackader. 8. Eye and Ear Diseases: Dr. Buller. 9. Venereal Disease, at the College: Drs. Stewart and Sutherland.

C. Out-Patients Clinic.—1. At Montreal General Hospital, Medical and Surgical.

Dr. Major will give special instructions in the dark room on the use of the laryngoscope and Dr. Buller on the use of the ophthalmoscope.

2. At University Dispensary, Gynecology on Tuesdays, Thursdays and Saturdays, 2.30 p.m.: Dr. Gardner. Diseases of Children, bi-weekly: Dr. Blackader. Diseases of the Skin, bi-weekly: Dr. Shepherd. Diseases of the Nervous System, bi-weekly: Dr. Stewart. 3.—At Montreal Dispensary: Drs. Stewart and Sutherland.

D. Clinical Instruction in Obstetrics at University Lying-in Hospital.—1. The management of cases of labor. 2. The after-care of cases.

II. PRACTICAL CASES.

1. Minor Surgery, including bandaging; application of splints; hæmostatics; catheterism, artificial respiration, &c.: Dr. Sutherland. 2. Operative Surgery—A complete course of operations on the cadaver, including amputations, excisions, ligations, etc. The students perform the operations in rotation; fee $5, to cover cost of material: Dr. Sutherland. 3. The Microscope in Medicine—A course of twenty-four lessons; microscopes, reagents, and material provided; fee $15: Dr. Wilkins. 4. Morbid Anatomy—Consisting of twenty demonstrations in the autopsy room of the Hospital. Students will make the post-mortems in rotation, and receive instructions in the method of performing them, and keeping record of their observations: Dr. Sutherland. 5. Obstetrical Operations and Presentations—A series of practical demonstrations on cadaver or phantom: Dr. A. A. Browne. 6. Practical Chemistry —same as and may be taken in lieu of the winter course; $12: Dr. G. P. Girdwood.

III. LECTURES.

1. Diseases of Children—Anatomical and physiological peculiarities of infancy, its hygiene and dietetics; methods of examining children; peculiarities of symptoms; diseases of the new-born, of infancy and of childhood, with their therapeutics: Dr. A. D. Blackader. 2. Hygiene—Lectures the same as and may be taken in lieu of the compulsory course in the winter session: Dr. R. L. Macdonnell.

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All students desirous of attending the above courses are expected to register their names with the Registrar *within one week* after the beginning of the Session, and to pay a *fee* of $20 (which includes registration fee). Enregistration and payment of the fee are compulsory upon all students, whether attending one or more of the classes. Time Table will be issued on April 1st. For further information apply to

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CHARLES INSLEE PARDEE, M.D., Dean of the Faculty; Professor of Otology; Surgeon to the Manhattan Eye & Ear Hospital.

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N M. SHAFFEN, M.D., Clinical Professor of Orthopœdic Surgery; Surgeon to New York Orthopœdic Hospital.

P. A. MORROW, M.D., Clinical Professor of Venereal Diseases; Surgeon to Charity Hospital.

THE PRELIMINARY SESSION will begin on Wednesday, September 17, 1884, and end October 1, 1884. It will be conducted on the same plan as the Regular Winter Session.

THE REGULAR WINTER SESSION will begin October 1, 1884, and end about the middle of March, 1885. The Plan of Instruction consists of Didactic and Clinical Lectures, recitations and laboratory work in all subjects in which it is practicable. To put the laboratories on a proper footing a new building has been erected at an expense of forty thousand dollars. It contains laboratories fitted for instruction in Chemistry, Histology, Pathology, Materia Medica, Operative Surgery, and Gynæcology.

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THE SPRING SESSION will begin about the middle of March and end the last week in May. The daily Clinics and Special Practical Courses will be the same as in the Winter Session, and there will be Lectures on Special Subjects by the Members of the Faculty.

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Pills, Ingluvin, &c.—W. R. Warner & Co., Philadelphia, Pa ..... Inset

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FOURTH.—Its harmless under prolonged use.
FIFTH.—Its prompt remedial efficacy in organic and functional disturbances caused by loss of nervous power and muscular relaxation.

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When taken into the stomach, diluted as directed, it stimulates the appetite and digestion, promotes assimilation and enters the circulation with the food—it then acts upon the nerves and muscles, the blood and the secretions. The heart, liver, lungs, stomach and genitals receive tone by increased nervous strength and renewed muscular fibre, while activity in the flow of the secretions is evinced by easy expectoration following the stimulant dose. The relief sometimes experienced by patients who have suffered from dyspnœa is so salutary that they sleep for hours after the first few doses.

Prepared by JAMES I. FELLOWS, Chemist.

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